DOCUMENT RESUME

ED 174 911 CG 013 702

TITLE	Developments In Aging: 1978: A Report of the Special Committee on Aging United Stated Senate, Ninety-Sixth Congress, First Session. Part 1 and Part 2 (Appendices).
INSTITUTION	Congress of the U.S., Washington, D.C. Senate Special Committee on Aging.
PUB DATE	79
NOTE	560p.
EDRS PRICE	MF02/PC23 Plus Postage.
DESCRIPTORS	Agencies; Community Education; *Community Service Programs; *Employment Opportunities; *Government Role; Health Needs; Inflation (Economics); *Minority Groups; *Older Adults; *Retirement; Taxes

ABSTRACT

This report of the Special Committee on Aging of the United States Senate pertains to problems and opportunities of older people, including matters of mainstreaming, health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activities, of securing proper housing, and of obtaining care and assistance. Appendices present the annual report of the Federal Council on Aging and Reports from Federal departments and agencies. (PJC)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED174911

96TH CONGRESS
1st Session

SENATE

REPORT
No. 96-55

PART 1

DEVELOPMENTS IN AGING: 1978

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 375, MARCH 6, 1978, AND
S. RES. 376, MARCH 6, 1978

Resolutions Authorizing a Study of the Problems
of the Aged and Aging

TOGETHER WITH

ADDITIONAL VIEWS

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM
THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS
STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF
EDUCATION POSITION OR POLICY

MARCH 30, 1979.—Ordered to be printed
Filed, under authority of the order of the Senate of March 29, 1979

U.S. GOVERNMENT PRINTING OFFICE
41-396 O WASHINGTON : 1979

CG013702

SPECIAL COMMITTEE ON AGING[1]

LAWTON CHILES, Florida, *Chairman*

FRANK CHURCH, Idaho
JOHN GLENN, Ohio
JOHN MELCHER, Montana
DAVID PRYOR, Arkansas
BILL BRADLEY, New Jersey
QUENTIN N. BURDICK, North Dakota

PETE V. DOMENICI, New Mexico
CHARLES H. PERCY, Illinois
JOHN HEINZ, Pennsylvania
NANCY LANDON KASSEBAUM, Kansas
WILLIAM S. COHEN, Maine

E. BENTLEY LIPSCOMB, *Staff Director*
DAVID A. AFFELDT, *Chief Counsel*
DAVID A. RUST, *Minority Staff Director*

---

[1] Amendment No. 23 to S. Res. 4, Reorganization of the Senate Committee System, agreed to Feb. 1, 1977, established the Special Committee on Aging as a permanent, nonlegislative committee under the rules of the Senate. Membership was reduced from 23 to 14 for the 95th Congress and by attrition must begin the 96th Congress with no more than 9 members. S. Res. 21, Jan. 23, 1979, increased the membership on the committee to 10. S. Res. 101, Mar. 13, 1979, increased the membership on the committee to 12.

LETTER OF TRANSMITTAL

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C., March 29, 1979.

Hon. WALTER F. MONDALE,
President, U.S. Senate,
Washington, D.C.

DEAR MR. PRESIDENT: Under authority of Senate Resolutions 375 and 376, agreed to March 6, 1978, I am submitting to you the annual report of the Senate Special Committee on Aging, Developments in Aging: 1978, Part 1.

Senate Resolution 4, the Committee Systems Reorganization Amendments of 1977, authorizes the Special Committee on Aging "to conduct a continuing study of any and all matters pertaining to problems and opportunities of older people, including, but not limited to, problems and opportunities of maintaining health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activity, of securing proper housing and, when necessary, of obtaining care and assistance." Senate Resolution 4 also requires that the results of these studies and recommendations be reported to the Senate annually.

Therefore, on behalf of the members of the committee and its staff, I am pleased to transmit this report to you.

Sincerely,

LAWTON CHILES, *Chairman.*

SENATE RESOLUTION 375, 95TH CONGRESS, 2D SESSION[1]

Resolved, That the Special Committee on Aging, established by section 104 of Senate Resolution 4, 95th Congress, agreed to February 4 (legislative day, February 1), 1977, is authorized from March 1, 1978, through February 28, 1979, in its discretion to provide assistance for the members of its professional staff in obtaining specialized training, in the same manner and under the same conditions as a standing committee may provide such assistance under section 202(j) of the Legislative Reorganization Act of 1946, as amended.

SEC. 2. In carrying out its duties and functions under such section and conducting studies and investigations thereunder, the Special Committee on Aging is authorized from March 1, 1978, through February 28, 1979, to expend $321,000 from the contingent fund of the Senate, of which amount (1) not to exceed $25,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $1,000 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of such act).

SEC. 3. The committee shall report its findings, together with such recommendations for legislation as it deems advisable, to the Senate at the earliest practicable date, but not later than February 28, 1979.

SEC. 4. Expenses of the committee under this resolution shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee, except that vouchers shall not be required for the disbursement of salaries of employees paid at annual rate.

SENATE RESOLUTION 376, 95TH CONGRESS, 2D SESSION[1]

To make sections 133(g), 134, and 202 of the Legislative Reorganization Act of 1946 applicable to the Special Committee on Aging.

Resolved, That section 104(a)(2) of Senate Resolution 4, 95th Congress, agreed to February 4 (legislative day, February 1), 1977, is amended by inserting "and for purposes of sections 133(g), 134, and 202 of the Legislative Reorganization Act of 1946," before "the special committee".

---

[1] Agreed to Mar. 6, 1978.

PREFACE

Almost 3 years remain before the next White House Conference on Aging is held. This provides an excellent opportunity for the administration and Congress to pull together the information needed for an effective conference, preceded by useful forums and State conferences. It also provides a means to take stock of what has and has not been accomplished since 3,400 delegates made a stirring call for action at the last White House Conference on Aging in 1971. Much progress, to be sure, has been made since the early 1970's. Social security benefits have been improved considerably. A supplemental security income program has been established to provide more adequate income for the aged, blind, and disabled. The mandatory retirement age for most workers in the private sector has been raised from 65 to 70, and the Federal Government banned mandatory retirement for practically all of its employees last fall. A national nutrition program for older Americans is now operating in every single State and provides more than 500,000 nutritious meals in a wide range of settings for older Americans 5 days a week.

However, major challenges exist in fashioning a national policy on aging. One good example is that our health care system is crisis oriented with a heavy institutional bias. Only a small portion of medicare, medicaid, and other Federal health expenditures are directed at home health care. Formidable barriers now make it difficult for many older Americans to receive home health care under medicare. Recently, Senators Chiles, Church, Burdick, Percy, Heinz, Cohen, and Kassebaum joined Senator Domenici in sponsoring a comprehensive home health package (S. 489). This bill includes several important features to make home health benefits more accessible, including the removal of the 3-day prior hospitalization requirement to qualify under part A (hospital insurance) of medicare, elimination of the 100-visit ceiling under both part A and part B (supplementary medical insurance), and making occupational therapy a primary service for a home health patient instead of a secondary service.

Another essential challenge is to control inflation, which not only erodes the purchasing power of the elderly but also threatens to undercut the integrity of public and private retirement systems. More and more now, older Americans are telling the Committee on Aging that a comfortable income a few years ago no longer stretches as far today. For millions of elderly persons, inflation is their number one problem. Rapidly rising prices have already had an enormous impact on social security, the civil service retirement system, and other income maintenance programs. Social security's recent need for additional financing—especially over the short range—was caused in large part by inflation. From July 1975 to December 1978, rising prices increased social security's outlays by an estimated $27.9 billion above and beyond what was initially forecast by Government experts in late 1973.

The Senate Committee on Aging will continue to focus on these challenges and other vital issues facing older Americans. The committee will attempt to gather facts upon which intelligent policy decisions can be made for older Americans today and tomorrow. Important spadework has already been performed in the overall hearings on retirement and work. One common theme has clearly emerged: The United States has no rational retirement policy today. Existing pension systems oftentimes operate as if they were in a vacuum. Private pension plans may be closely connected with social security; others are loosely related; and some have no relationship whatsoever. And, confusion often abounds for those planning for their retirement.

The committee will examine another closely related question: What should be the appropriate mix for the various components of what might be termed our loosely knit retirement policies? At present, our income maintenance system can be analogized to a three-legged stool. The first leg is the social security system which provides partial replacement for lost earnings because of retirement in old age, death, or disability. In one form or another, it affects almost every American family. About 110 million persons pay into social security as employees or self-employed persons. Nearly 95 percent of all individuals now reaching age 65 are eligible for social security. For most older Americans, social security is their economic mainstay—accounting for more than half the income for about 7 out of 10 aged beneficiaries and 1 out of 2 elderly couple beneficiaries.

Private efforts, such as pensions, insurance, and savings, represent the second leg in the three-legged income maintenance stool. Nearly half of private-sector wage earners—or 48 million in all—work in jobs covered by private pension plans. More than 650,000 Keogh plans for self-employed people and 1,500,000 individual retirement arrangements for wage earners have been established. However, most older Americans today do not have a pension. Those fortunate enough to qualify frequently receive small benefits. In fact, only about 20 percent of all people 65 or older now receive a private pension. An additional 9 percent receive a government pension.

The third leg is means-tested assistance programs, such as supplemental security income, for persons with incomes insufficient to meet basic needs. About 2 million persons 65 or older receive SSI benefits. They are now assured a minimum monthly income of $189.40 for individuals and $284.10 for couples.

Several fundamental—and at times controversial—questions arise in any objective examination of our existing retirement system, including:

—What is the appropriate role for private efforts, social security, and SSI?

—Should any or all of these systems be revamped, restructured, or perhaps replaced?

—Should social security be a universal system so that employees of Federal, State, and local governments would be covered under the program?

—Should the social security payroll tax be the only source of financing for the cash benefits program or should some other source be used to pay some of the costs?

These questions are being addressed in one way or another by several distinguished advisory groups, including the Social Security Advisory Council, the National Commission on Social Security, the Universal Coverage Study Panel, and the President's Retirement Policy Commission. The committee will follow closely the deliberations of these groups and their recommendations.

The inquiry into neighborhoods represents another effort by the committee to provide an umbrella context for related questions which are often considered individually. National attention was directed at neighborhood-related issues when elderly residents of a San Francisco hotel were forcibly evicted in 1977. Subsequent committee on-site investigations and hearings have revealed that many aged are in a desperate situation in finding decent and affordable housing. In addition, Federal urban renewal policies frequently have destructive results for older Americans. These problems may intensify as a part of a massive shift in urban dynamics occurring throughout our Nation. However, the committee is encouraged by many constructive, cost-effective, and nonbureaucratic efforts at the local level to revitalize cities with minimum disruption for the neighborhood inhabitants. Older Americans—perhaps more so than other groups in our society—have the greatest need for strong and stable neighborhoods. They are likely to be the chief victims if they are forced to reside in rundown neighborhoods with substandard housing and inadequate public services.

Waste and fraud in government, always intolerable, is even more so when this Nation must face up to the need for reduced deficits and greater budgetary responsibility. Preliminary hearings on State antifraud units suggest that much more must be learned about the proper Federal-State "mix" of responsibility in combating fraud and abuse. The personal losses which fraud can cause should not be overlooked. Last year, the committee focused special attention on unethical and unscrupulous practices in the sale of "medi-gap" policies. Most agents who sell supplementary medical policies to older Americans are decent, hard working, and honest. However, there will always be "opportunists" who will attempt to take advantage of the unsophisticated or unsuspecting. These hearings helped provide the framework for the introduction of a Medicare Supplemental Health Insurance Information Disclosure and Protection Act. Strong bipartisan support has already been expressed for this proposal. A coalition for action, involving private insurers as well as State and Federal agencies, is now underway. The committee will keep close watch of its progress.

Self-evident as it may seem, it is not always realized that national goals for retirement income adequacy must consider health care costs in the equation. Medicare provides valuable protection, but it only does part of the job. In some respects, it is like a leaky umbrella. Much of medicare's reimbursement is targeted toward acute care when greater attention to chronic care may be more appropriate—especially as our "older" aged population continues to increase rapidly. A clear-cut and sound policy on alternatives in long-term care is needed now.

These challenges take on added importance as we move toward the next White House Conference because our society is becoming older. Today, one out of nine Americans is 65 years or older. In 50 years from now, about one out of every five or six persons will be an older American, or 55 million in all. In terms of sheer numbers, we, as as a Nation, have a vital stake in these demographic changes which are becoming more apparent and will accelerate in the years ahead.

Lawton Chiles,
Chairman.
Pete V. Domenici,
Ranking Minority Member.

CONTENTS

Page
Letter of transmittal iii
Senate Resolution 375, 95th Congress, 2d session v
Senate Resolution 376, 95th Congress, 2d session v
Preface vii
Every ninth American xv
Chapter I.—Adjusting to an "aging population" 1
  I. The trends 3
    A. The statistical underpinnings 3
    B. Questions about the "dependency ratio" 6
  II. The retirement policy thicket 8
    A. In search of a national policy 9
    B. The trend to early retirement 14
    C. Minority concerns 17
  III. Potential role of broadened work opportunities 19
    A. The positive side: What is already happening 20
    B. The private sector 21
    C. Federal Government as a model employer? 22
  IV. Lifelong learning 24
  V. The graying of the budget: Questions 27
  VI. Conclusion 29
Chapter II. Inflation and retirement income 31
  I. Rises in cost of living 32
  II. Areas of special impact on the elderly 33
  III. Impact on retirement systems 34
  IV. Cost-of-living increases for older Americans 35
  V. Meaning of the new poverty statistics 36
  VI. An end to poverty: How near? 39
Chapter III. Health: High costs and new approaches 42
  I. The individual burden 42
  II. Elusive goal: Hospital cost containment 43
    A. Costs continue to rise 43
    B. Voluntary effort 43
    C. Legislation fails 43
    D. State initiatives 44
  III. Increasing attention to "alternatives" 44
    A. The administration: Behind schedule 48
    B. Legislative efforts 52
    C. The Older Americans Act breakthrough 54
  IV. Vision care and a graying population 55
  V. Mental health: New reports, setbacks, and new possibilities 56
    A. The studies 57
    B. Legislative action 58
    C. Possibilities for 1979 59
    D. NIMH-AoA joint session 60
  VI. National health insurance and the elderly 60
    A. Extent of the problem 61
    B. What is to be done? 61
    C. Paying for national health insurance 65
    D. Implications for older Americans 65
    E. Strong support from organizations 66
    F. Health subcommittee hearings 66

Page

- Chapter IV. Fraud and abuse: How much? 68
  - I. The estimates 69
    - A. Medicaid losses 69
    - B. Medicare losses 69
  - II. The State fraud control units 70
  - III. Medicare-medicaid provider ownership disclosure 72
  - IV. Administration initiatives 72
  - V. The GAO assessment(s): The Secretary's conference on fraud, abuse, and errors 74
- Chapter V. New directions in nursing home care? 76
  - I. The HEW review and hearings 76
    - A. The "specifications" 77
    - B. Public comments 78
    - C. New fire regulations 79
  - II. Hearings focus on quality of care 79
    - A. Chicago testimony 79
    - B. Washington hearing 81
  - III. Federal Trade Commission investigates nursing home practices 81
  - IV. Quality of care: Studies and action 82
    - A. The National Citizens' Coalition for Nursing Home Reform 82
    - B. Ombudsman directors coalesce 83
    - C. Investigations 84
    - D. Community involvement 84
    - E. Legislation 85
  - V. Family responsibility 86
    - A. Massachusetts 86
    - B. Prohibiting the transfer of assets 86
    - C. Gray Panthers win suit on spouse deeming 87
- Chapter VI. Medi-gap, other consumer issues 88
  - I. High pressure medi-gap sales draw fire 88
    - A. Common benefits and types of medi-gap insurance 90
    - B. The committee's hearings: Problems in the marketplace 92
    - C. Additional evidence of abuses 98
    - D. Actions taken since committee hearings 99
  - II. Incentives for consumer co-ops 101
  - III. Protection for electronic fund transfers 102
  - IV. Rules for hearing aids and funerals? 103
- Chapter VII. A revised Older Americans Act 106
  - I. 1978 extent of Older Americans Act operations 107
  - II. The new framework 108
    - A. Consolidating titles III, V, and VII 108
    - B. Organization 110
    - C. Home-delivered meals 112
    - D. Senior centers 113
    - E. Legal services 113
    - F. Administration 114
    - G. Disaster relief 114
    - H. Surplus commodities 114
  - III. Social and nutrition services authorization 114
  - IV. The expanded title IV 115
    - A. Training 115
    - B. Research 115
    - C. Demonstration projects 116
    - D. Special projects in long-term care 116
    - E. Special demonstrations in legal services 117
    - F. Other special demonstrations 117
  - V. Title V—community service employment 118
  - VI. Title VI—direct funding of Indian tribes 119
- Chapter VIII. Changes in ACTION, CSA 120
  - I. ACTION programs 120
    - A. Older American volunteer programs reauthorized for 3 years 120
    - B. Funding authorizations increased 121
    - C. Program changes 121
    - D. A transfer to the Administration on Aging 122
    - E. Administration fiscal year 1980 budget request 123

Chapter VIII.—Changes in ACTION, CSA—Continued

Page
II. Community Services Administration 123
A. Reauthorization of Economic Opportunity Act 123
B. Energy crisis intervention—a confusing history 125
Chapter IX. New initiatives on housing and community issues 127
I. The 1978 housing act 128
II. Congregate housing services 130
III. Inquiries into changing neighborhood dynamics 133
IV. Report on SRO quarters 136
V. Hearings on condominiums 136
VI. Reverse mortgages approved 139
Chapter X. Transportation: Slow progress toward better mobility 142
I. The new Federal transportation bill 142
A. Senate action 142
B. Revisions in conference 143
II. The issue of barrier-free access 144
A. Transbus: Revision of the 1977 mandate 145
B. DOT's proposed accessibility regulations 146
III. Continuing efforts to resolve insurance problems 148
Chapter XI. Areas of continuing or emerging concern 151
I. Minorities 151
A. National Center on Black Aged 154
B. New developments affecting Indian elders 156
C. Activities of the Asociacion Nacional Pro Personas Mayores 157
D. Final report on the Pacific/Asian elderly 159
II. Developments in Age Discrimination Act 160
A. The 1978 amendments 161
B. The proposed regulations 162
C. Implementation 164
III. Actions on energy costs, weatherization 165
A. The national energy act 165
B. The GAO weatherization report 167
C. Concern about utility terminations 168
IV. National Institute on Aging 169
A. The research plan 170
B. Biomedical research 170
C. Behavioral and social science research 171
D. Research on human services and delivery systems 172
V. One-year increase in title XX ceiling 172
VI. Crime and the elderly 174
A. The proposed LEAA reorganization 175
B. Victim assistance defeated in House 176
C. Activities of the National Committee on Crime and the Elderly 178
VII. Education programs for the older adult 179
A. Community education 180
B. Other programs 180
C. Lifelong learning 181
VIII. Employment 182
A. Comprehensive Employment and Training Act Amendments 182
B. Senior community service employment 183
C. Title X older workers projects 184
D. Flexible and Compressed Work Schedules Act 185
E. Federal Employees Part-Time Career Employment Act 185
F. Age Discrimination in Employment Amendments of 1978 (Public Law 95-256) 186
G. Humphrey-Hawkins: The Full Employment and Balanced Growth Act of 1978 (Public Law 95-523) 187
IX. New actions on pensions 188
A. ERISA reorganization and other changes 188
B. Court actions affecting pensions 191
C. New looks at the pension system 193

Chapter XI.—Areas of continuing or emerging concern—Continued Page
X. Taxes and the elderly ... 194
A. Revenue Act of 1978 ... 194
B. Tax counseling assistance ... 197
C. Tax credit for the elderly ... 197
D. The Energy Tax Act of 1978 ... 198
XI. White House Conference on 1981 ... 198
XII. United States, U.N. action on a world assembly in 1982 ... 200
Additional views of Senator Heinz ... 202

SUPPLEMENTAL MATERIAL

Supplement 1. Hearings held by the Special Committee on Aging during 1978 and January-March 1979 ... 203
Supplement 2. Publications list ... 204
Index—hearings and reports, 1978 ... 221

EVERY NINTH AMERICAN [1]

When we declared our independence, every 50th American was a so-called older person (aged 65-plus). They came to some 50,000 out of an estimated total population of 2.5 million or 2 percent.

By the beginning of this century, the numbers of older persons had increased more rapidly than the young and represented every 25th American.

At the beginning of 1979, the estimated 24.4 million older Americans made up just over 11 percent of the population—"Every Ninth American."

But something quite different with new potentials for study and concern is also becoming evident. In the past, since the proportion of older persons in the population grew somewhat faster than did the other age groups, we had a growing total population, including the aged. The recent trends, however, have been different. The fertility rates since the end of the postwar baby boom have actually been below zero population growth so that continuation and the passage of time will bring us an aging society with an increasing median age.

Even cursory consideration indicates the implications for shifting of product markets, clothing styles, social and recreational facilities, types of housing, health care facilities, entertainment, et cetera.

STATE HIGHLIGHTS

In mid-1978, the largest concentrations of older persons—13 percent or more of a State's population—occurred in five States: Florida (17.6), Arkansas (13.4), Iowa (13.1), and Missouri and South Dakota (both at 13 percent).

California and New York each had more than 2 million older people while Florida, Pennsylvania, Texas, Illinois, and Ohio each had more than 1 million.

Almost a quarter of the Nation's older people lived in just three States (California, New York, and Florida). Adding five more States (Pennsylvania, Texas, Illinois, Ohio, and Michigan) brings the eight-State total to almost half the older population of the United States. It takes 11 more States (New Jersey, Massachusetts, Missouri, Indiana, North Carolina, Wisconsin, Tennessee, Georgia, Virginia, Minnesota, and Alabama) or a total of 19 to account for just under three-quarters of the older population. It requires an additional 11 States, or a total of 30, to include 90 percent. The remaining 10 percent of the 65-plus population lives in the remaining 21 States and the District of Columbia. (See exhibit A, page XXV, for a more detailed analysis of recent State trends.)

What is the older population like, and how does it change?

---

[1] Prepared by Herman B. Brotman, consultant to the Special Committee on Aging, U.S. Senate, and former assistant to the Commissioner on Aging, Department of Health, Education, and Welfare.

GROWTH IN NUMBERS

During the 70 years between 1900 and 1970 (the last census), the total population of the United States grew almost threefold while the older part grew almost sevenfold. The 65-plus population continues to grow faster than the under-65 portion; between 1960 and 1970, older Americans increased in number by 21 percent as compared with 13 percent for the under-65 population.

The most rapid growth (the largest percentage increases) in 1960–70 occurred in Arizona (79 percent), Florida (78.2), Nevada (70.4), Hawaii (51.3), and New Mexico (37.7), all States with a large number of in-migrants. These five States also had the fastest growth rates in 1970–78. Florida still has the highest proportion of older people—17.6 percent in 1978 (14.5 in 1970). Alaska, with just over 2 percent, remains the State with smallest number and smallest proportion of older persons (10,000 or 2.5 percent in 1978).

TURNOVER

The older population is not a homogeneous group nor is it static. Every day, approximately 5,000 Americans celebrate their 65th birthday. Every day, approximately 3,500 persons aged 65-plus die. The *net* increase is about 1,500 a day, or a half million a year, but the 5,000 "newcomers" each day are quite different from and have lived through a quite different life history than those already 65-plus and are worlds apart from those already centenarians who were born shortly after the Civil War.

AGE

As of mid-1978, most older Americans were under 75 (62.1 percent); over half were under 73; and more than a third (35.6 percent) were under 70. Over 2.2 million Americans are 85 years of age or over. Accurate data on the number of centenarians is not available, but about 10,690 persons (end of 1976) are receiving cash social security benefits after producing some "proof of age' that shows ages of 100 or more. (See Projections, page XXIII, for changes in age distribution in the future.)

PERSONAL INCOME

Older economic units continue to have half the income of their younger counterparts. In 1977, half of the families headed by an older person had incomes of less than $9,110 as compared with $17,203 for families with under-65 heads; the median income of older persons living alone or with nonrelatives was $3,829 compared with $7,674 for under-65 unrelated individuals.

Some 3.2 million or a seventh of the elderly had incomes below the official poverty thresholds ($3,637 for older couples and $2,895 for older individuals). This is a significant improvement over the 4.7 million or quarter of the elderly who lived in "poor" households in 1970 and results primarily from the increases in social security benefits.

Women and minority aged are heavily overrepresented among the aged poor. Many of the aged poor became poor after reaching these ages because of the half to two-thirds cut in income that results from retirement from the labor force.

The theoretic retired couple budget prepared by the Bureau of Labor Statistics for a modest but adequate intermediate standard of living came to $7,198 in autumn 1977. A lower budget came to $5,031; a higher came to $10,711.

INCOME SOURCES AND FINANCIAL STATUS

The Bureau of Labor Statistics' Consumer Expenditure Survey for 1972 and 1973 also collected data on income, taxes, and value of and net change in assets. For the purpose of the survey, "family" includes both a group of persons related by blood or marriage living in a single household and unrelated individuals living alone or with nonrelatives (see exhibit B, page XXX, for more detailed data and for information on the characteristics of the "families").

A summary of the highlight shows the following by age of family head:

Category	Average annual		
		65-plus	
	Under 65	Amount	Index: Under 65 equals 100
Money income before taxes	$12, 702	$6, 292	50
Wages and salaries	10, 294	1, 524	15
Self-employment	994	402	40
Social security and railroad retirement	201	2, 085	1, 040
Government retirement, veterans, unemployment	253	450	178
Income from assets investments, etc	383	1, 134	296
Other, including welfare, contributions, pensions, etc	577	697	121
Personal taxes	1, 978	528	27
Income after taxes	10, 728	5, 764	54
Other money receipts	227	188	82
Goods and services received	149	68	46
Mortgage principal paid	−358	−76	21
Net increase in assets	942	353	38
Market value of financial assets	5, 490	13, 511	246

The older units had about half the income of the younger, primarily because the larger amounts from retirement benefits and income from investments for the older families did not balance out the loss of earnings from employment. As is to be expected, the financial assets of older families was greater than for the younger. Not as expected was the net increase in assets held by the elderly albeit at a lower figure than for the younger units; this is a result of the fact that older persons not only add less new assets but tend to avoid new liabilities completely.

EXPENDITURES

Older Americans spend proportionately more of their income on gifts and contributions, food, housing, and health and personal care and less on other items in a pattern generally similar to that of other low income groups. Persons living on fixed incomes are hit hard by price inflation and the elderly command little potential for personal improvement of income. Even formulas that adjust retirement payments for changes in price indices are of only partial assistance since, at best, they provide only for a restoration of the previous living standard, they provide the "catch-up" well after the fact, and older people have little in easily available savings to carry them over.

The BLS survey (see exhibit B) shows the following by age of family head:

Category	Average annual			Distribution		
		65-plus			65-plus	
	Under 65	Amount	Index[1]	Under 65	Percent	Index[1]
Total	$10,059	$5,400	54	100.0	100.0	100
Insurance and pension	874	176	20	8.7	3.3	38
Gifts and contributions	410	490	120	4.1	9.1	222
Other consumption	8,775	4,734	54	87.2	87.7	101
Food	1,831	1,155	63	18.2	21.4	118
Alcoholic beverages	86	30	35	.9	.6	67
Tobacco products	146	60	41	1.4	1.1	79
Housing	2,619	1,559	60	26.0	28.9	111
House furnishings and equipment	438	174	40	4.4	3.2	73
Clothing	737	290	39	7.3	5.4	74
Transportation (excluding trips)	1,801	689	38	17.9	12.8	72
Health care (out of pocket)	480	448	94	4.8	8.3	173
Personal care	105	82	78	1.0	1.5	150
Recreation	712	336	47	7.1	6.2	87

[1] Index: Under 65 equals 100.

INCOME MAINTENANCE

Old Age, Survivors, and Disability Insurance

In September 1978, the Social Security Administration paid cash benefits to 34.4 million persons of all ages for a total of $7,829 million. Subtracting the 4.9 million under-65 disabled workers and their dependents (paid benefits from the disability insurance trust fund) there remains 29.9 million persons and $6,839 million in payments.

For retired workers and their dependents, the average monthly payment to the retired worker was $261.51; to their wives and husbands, $132.01; and to their children, $103.83. Almost 60 percent of all retired workers are receiving "reduced benefits," having started to draw benefits before attaining age 65.

For survivors of deceased workers, the average monthly payment to widowed mothers or fathers with children was $188.26; to the children, $180.59; to older and disabled widows and widowers, $238.27; and to parents, $213.09.

Special age-72 beneficiaries receive $82.93 plus 50 percent more for a wife.

Of the total 34.4 million beneficiaries in September 1978, 22.3 million or about 65 percent were aged 65 plus, as follows: 16.3 million retired workers, 5.9 million survivors and dependents, and 139,000 special age-72 beneficiaries.

Supplementary Security Income

In September 1978, the Social Security Administration sent checks to 1,993,000 65-plus persons eligible because of age and need, totalling $200.8 million. Of this amount, $147 million was State supplements administered by the Federal agency for the 27 States that have made such an arrangement. Two States pay no State supplement and 22 pay supplements (totalling $15 million) directly to their own eligible aged residents under the State law.

In addition, it is estimated, about 23,000 65-plus persons received SSI payments as "blind" and 260,000 as "disabled" beneficiaries with higher payments.

HEALTH

Total Health Costs

The total health bill in the United States rose from $38.9 billion in 1965, when it amounted to 5.9 percent of the gross national product, to $162.6 billion in 1977, 8.8 percent of the GNP. This more than tripling of the costs of health care results from vast technical changes, very rapid price increases, the "aging" of the population, and the increased utilization made possible by the provision of increased resources, especially through public programs.

In this period, hospital care costs rose most rapidly, proportionately from 34 percent of total costs to 40 percent; nursing home costs rose from 3 percent to 8 percent of the total; the other components increased in amounts but decreased proportionately.

Personal Health Care Expenditures

These expenditures (which exclude costs of research, construction, and certain public health activities like control of contagious diseases) rose from $33.5 billion in 1965 to $142.6 billion in 1977.

Per capita health care costs in 1977 for an older American came to $1,745, 3.4 times the $514 spent for each under-65 person. $769 or 44 percent of the $1,745 went for hospital care, $446 or about 26 percent for nursing home care, $302 or 17 percent for physician services, $121 or 7 percent for drugs, $43 or almost 3 percent for dentists' services, and the small remainder for all other items.

Older people represent 11 percent of the total population but account for 29 percent of total personal health care expenditures ($41.3 billion out of a $142.6 billion).

Of the $41.3 billion total personal health care expenditure for older persons in 1977, only $13.6 billion or 33 percent came from private sources; of the $27.6 billion or 67 percent paid for from public sources, $18.3 billion or 44.3 percent came from medicare, $6.9 billion or 16.7 percent came from medicaid, and the remaining $2.5 billion or 6 percent came from a variety of smaller programs.

Comparison of levels and sources of payments on a per capita basis over the last 11 years shows the following:

Age and year	Total	Direct out of pocket	3d-party payments: Total	3d-party payments: Government	3d-party payments: Private health insurance	3d-party payments: Philanthropy and industry
Amount:						
Under 65:						
1966	$155	$79	$76	$30	$42	$3
1977	514	164	350	150	187	13
65-plus:						
1966	445	237	209	133	71	5
1977	1,745	463	1,282	1,169	101	13
Distribution (percent):						
Under 65:						
1966	100.0	51.1	48.9	19.4	27.3	2.2
1977	100.0	31.9	68.1	29.1	36.4	2.6
65-plus:						
1966	100.0	53.2	46.8	29.8	15.9	1.
1977	100.0	26.5	73.5	67.0	5.8	0.

It should be noted that the above comparison shows a significant increase in the utilization of health care in addition to a doubling of health care prices, with a pronounced shift toward third-party payments, especially public programs.

Health Status

In a recent household interview survey of a sample of the noninstitutional population, over two-thirds (69 percent) of the older persons reported their health as good or excellent as compared with others of their own age. Almost 22 percent reported their health as fair and 9 percent as poor. Minority group members, residents of the South, residents of nonmetropolitan areas, and persons with low incomes were more likely to report themselves in poor health.

Counting older people in institutions as, by definition, in poor health, a total of 14 percent of all older people consider themselves in poor health.

The most frequently reported chronic conditions are: Arthritis (44 percent), hearing impairments (29 percent), and vision impairments, hypertension, and heart conditions (each about 20 percent).

While over 80 percent of the noninstitutional older population reported some chronic condition, less than 18 percent said that it limited their mobility. Some 5 percent were confined to the house (but only slightly over 1 percent were bedridden); almost 7 percent needed help in getting around (less than 2 percent needed the help of another person and less than 5 percent needed an aid like a cane, walker, or wheelchair); and almost 6 percent could move around alone, but with some difficulty.

Utilization

Older people are subject to more disability, see physicians about 50 percent more often, and have about twice as many hospital stays that last almost twice as long as is true for younger persons. Still, some 82 percent reported no hospitalization in the previous year.

Based on data for 1974, on the average, a person aged 55–64 spends 2 days per year in a short-stay hospital. This increases to an average of 3.3 days for persons aged 65–74 and to 5.6 days for those 75 plus.

On the average, a person aged 55–64 spends a fraction of a day per year in a nursing home, with a jump to 4.4 days for persons aged 65–74, 21.5 days for those aged 75–84, and 86.4 days for those 85 plus.

Of the 1.1 million older people in nursing homes at the time of a 1977 study, 19 percent were aged 65–74, 41 percent were 75–84, and 40 percent were 85 plus; in the total older population, the comparable percentages were 62, 29, and 9. In the nursing home population, 74 percent were women (60 in the total), 69 percent were widowed, 14 percent were single, and 12 percent married; 93 percent were white. Of every 100 admissions to nursing homes in 1973–74 almost 40 came from their own private residences (only 13 had been living alone), 36 came from general hospitals, 14 from other nursing homes or related facilities, and the rest came primarily from mental institutions and boarding homes.

Death Rates

In the period between 1965 and 1976, annual death rates for older persons dropped about 11 percent from 6.1 per 100 to 5.4 per 100. Within the older population, there were these variations: The rate for persons 65–74 dropped 18 percent from 3.8 to 3.1 per 100; the rate for those 75–84 declined 11 percent from 8.2 to 7.3 per 100; while the rate for the 85-plus dropped 23 percent from 20.2 to 15.5.

The rate for deaths of older persons from heart disease dropped 14 percent, from 2.8 to 2.4 per 100 per year and the rate for deaths from stroke dropped 22 percent, from 0.9 to 0.7 per 100. On the other hand, the rate for deaths from cancer increased 11 percent, from 0.9 to 1.0. Still, these three causes of death accounted for three-quarters of the deaths of older people in both 1965 and 1976.

LIFE EXPECTANCY

Based on death rates in 1976, average life expectancy at birth was 72.8, 69.0 years for males but almost 8 years longer or 76.7 for females. At age 65, average remaining years of life were 16.0, 13.7 for men but more than 4 years longer or 18.0 for women. The 25-year increase in life expectancy at birth since 1900 results from the wiping out of most of the killers of infants and of the young—much smaller improvement has occurred in the upper ages when chronic conditions and diseases become the major killers. Many more people now reach age 65 (about 75 percent versus 40 percent in 1900) but, once there, they live only 4.1 years longer than did their ancestors who reached that age in the past. Should recent decreases in death rates continue among older persons, especially from cardiovascular conditions, life expectancy in the later years may increase further.

SEX RATIOS

As a result of the yet unexplained longer life expectancy for families, most older persons are women—13.9 million as compared with 9.6

million men in mid-1977. Between ages 65 and 74, there are 130 women per 100 men; after 74, there are 178. In the 85-plus group, there are 217 women for every 100 men. The average for the total 65-plus population is 146 women per 100 men. (See also, "Projections," below.)

MARITAL STATUS

In 1978, most older men were married (7.1 million or 78 percent) but most older women were widows (6.9 million or 52 percent). There are 5.3 times as many older widows or widowers. Among 75-plus women, almost 70 percent were widows. About 35 percent of the married 65-plus men have under-65 wives. In 1976, among the 2.2 million marriages of persons of all ages, there were about 20,800 brides and 39,800 grooms aged 65-plus. For about 1,200 of these older brides and 2,000 older grooms, it was a first marriage. For the remainder, it was a remarriage, mostly after widowhood rather than divorce. Marriage rates for older men were seven times those for older women for marriages in 1976; for first marriages, the rates for older men were 2.5 times those for older women; for remarriages, the rate for men was 8.8 times that for women.

EDUCATIONAL ATTAINMENT

In 1978, almost half (46 percent) of the older Americans had not completed one year of high school; the median for the 25–64 age group was high school graduation. About 2.2 million or 10 percent of the older people were "functionally illiterate," having had no schooling or less than 5 years. At the other end of the scale, about 8 percent were college graduates.

LIVING ARRANGEMENTS

In 1978, more than 8 of every 10 older men, but less than 6 of every 10 older women, lived in family settings; the others lived alone or with nonrelatives except for the 1 in 20 who lived in an institution (1 in 5 in the 85-plus age group). About three-quarters of the older men lived in families that included the wife but only one-third of the older women lived in families that included the husband. Four of every 10 older women lived alone. More than three times as many older women lived alone or with nonrelatives than did older men.

PLACE OF RESIDENCE

In 1978, a slightly smaller proportion of older than of younger persons lived in metropolitan areas (62 versus 67 percent). Within the metropolitan areas, however, about half of the older people lived in the central city but almost 60 percent of the under-65 lived in the suburbs. The inevitable aging of the residents of the suburbs which began their rapid expansion in the post-World War II period will soon bring a reversal of proportions and the development of the same problems, lacks, and barriers faced by the inner city aged.

VOTER PARTICIPATION

In the 1976 Presidential election, older people made up 15 percent of the voting age population but cast 16 percent of the votes. Some 62 percent of the older population voted, a much higher proportion than the under-35 group but somewhat lower than the 35–64 groups. A higher *proportion* of older men than women voted, but the women still outnumbered the men voters. Voter participation falls off sharply after age 75.

MOBILITY

In the March 1978 household survey 13.7 percent or 3.1 million of the persons then aged 65-plus reported that they had moved from one residence to another in the 3-year period since March 1975. In a pattern that has remained consistent for a long period of time, remembering that most moves are made for occupational reasons, some 8.4 percent of the elderly moved within the same county, 2.9 percent moved to a different county within the same State, and only 2.3 percent moved across a State line. The impression that there is more extensive interstate migration of older people arises from the very visible flow but only toward a very few States—Florida, Arizona, and Nevada.

EMPLOYMENT

In 1978, just over 20 percent of 65-plus men (1.9 million) and 8 percent of 65-plus women (1.1 million) were in the labor force with concentrations in three low-earnings categories: Part time, agriculture, and self-employment. Unemployment ratios were low due partly to the fact that in a period of sizable unemployment discouraged older workers stop seeking jobs and are not counted as being in the labor force at all. For those remaining actively in the labor force and counted as unemployed, the average duration of unemployment was longer than for younger workers.

AUTOMOBILE OWNERSHIP

As is true for most major household appliances, ownership of automobiles by older households is considerably below that of households with younger heads but at least part of the difference depends on income level rather than age, health, or choice. A 1974 Census Bureau survey shows that 62 percent of older households owned at least one car as compared with 86 percent of younger households. However, there is a strong relationship between automobile ownership and income level at all ages and a much higher proportion of low-income households among the elderly—thus accounting, in part, for the lower ownership in older households.

PROJECTIONS

The "safest" Census Bureau population projections of the size and composition through 2050 are the so-called "series II" which are based on an ultimate cohort fertility rate of 2.1 (an ultimate level of 2.1 children per woman or eventual zero population growth), small improvements in life expectancy including that for older persons, narrowing of the gap between white and black rates, constant 400,000 net immigration, and no new major medical "cures" of chronic diseases.

XXIV

POPULATION PROJECTIONS (SERIES II), TOTAL AND 65 PLUS BY SEX, 1977-2050

[Numbers in thousands]

Year	All ages	65-plus				
		Both sexes			Female	
		Number	Percent of all ages	Male	Number	Per 100 men
1977	216, 745	23, 431	10. 8	9, 545	13, 885	145
1980	222, 159	24, 927	11. 2	10, 108	14, 819	147
1985	232, 880	27, 305	11. 7	11, 012	16, 293	148
1990	243, 513	29, 824	12. 3	11, 999	17, 824	149
1995	252, 750	31, 401	12. 4	12, 602	18, 799	149
2000	260, 378	31, 822	12. 2	12, 717	19, 105	150
2005	267, 603	32, 436	12. 1	12, 924	19, 512	151
2010	275, 335	34, 837	12. 7	13, 978	20, 858	149
2015	283, 164	39, 519	14. 0	16, 063	23, 456	146
2020	290, 115	45, 102	15. 6	18, 468	26, 634	144
2025	295, 742	50, 920	17. 2	20, 861	30, 059	144
2030	300, 349	55, 024	18. 3	22, 399	32, 624	146
2035	304, 486	55, 805	18. 3	22, 434	33, 371	149
2040	308, 400	54, 925	17. 8	21, 816	33, 108	152
2045	312, 054	54, 009	17. 3	21, 3[illegible]	32, 674	153
2050	315, 622	55, 494	17. 6	22, 055	33, 439	152

If the present fertility rate of approximately 1.8 should continue at this low level rather than the 2.1 rate assumed above, the size of the total population would be smaller and the *proportion* of older people would be larger. The increasing number and proportion of older persons reflects both the impact of longer life expectancy and the movement of the post-World War II baby boom through the population pyramid. Projections based on lower fertility rates also shows a much slower rate of growth of the older population after 2030 when today's babies and youngsters start reaching age 65.

The above projections represent averages. Important differences by sex and age group within the 65-plus are shown as follows:

POPULATION PROJECTIONS, TRENDS WITHIN THE 65-PLUS AGE GROUP, 1977-2050

[Percent change]

Sex	1977-2000	2000-25	2025-50
Both sexes, 65 plus	+35. 8	+60. 0	+9. 0
65 to 74	+19. 6	+77. 5	−6. 7
75 to 84	+56. 0	+41. 1	+14. 0
85 plus	+84. 1	+32. 4	+91. 6
Male, 65 plus	+33. 2	+64. 0	+5. 7
65 to 74	+21. 3	+79. 1	−6. 3
75 to 84	+54. 7	+44. 1	+13. 5
85 plus	+64. 4	+29. 9	+92. 9
Female, 65 plus	+37. 6	+57. 3	+11. 2
65 to 74	+18. 3	+76. 2	−7. 1
75 to 84	+56. 8	+39. 4	+14. 3
85 plus	+93. 2	+33. 4	+91. 1

Thus, comparison of the 25-year time spans shows continuing increase to 2000, very rapid growth from 2000 to 2025 as the post-war babies reach their later years, and a sharp deceleration as the current low birth rates are reflected in older people. Significantly, the traditionally more rapid growth of the older women is reversed in the 2000 to 2025 period. But of even greater significance is the fact that between now and 2000 the oldest part of the older population will grow most rapidly, then be reversed between 2000 and 2025, and return to the current trend after 2025.

Does the age shift in the population create insurmountable "burdens"? Computation of a gross dependency ratio based on the assumption that the young and the old are dependent on the middle group, the so-called productive-age population, tends to show a reasonable "burden" on the middle group under reasonable economic and labor force assumptions, as follows:

Year	Number aged under 18 per 100 aged 18 to 64	Number aged 65-plus per 100 aged 18 to 64	Total
1970	61.1	17.6	78.7
1977	49.7	18.2	67.9
2000	43.2	20.0	63.2
2025	42.1	29.6	71.7
2050	41.7	30.2	71.9

Exhibit A

Recent State Trends in the Older Population, 1970–78

Between 1970 and 1978, the Nation's older population (65-plus) increased from 20 million to 24.1 million at a rate faster than did the under-65 population as has been true for most of the twentieth century. These national trends, however, represent the averaging out of a variety of separate State trends. Details are presented in the tables and analyses that follow.

PROPORTION OF POPULATION AGED 65 PLUS

For the Nation as a whole (50 States and District of Columbia), the proportion of the total population in the 65-plus group rose from 9.8 percent in 1970 to 11 percent in 1978. In Wyoming, the under-65 population grew faster and the proportion aged 65-plus actually dropped from 9.1 percent in 1970 to 8.4 percent in 1978. In four other States (Alaska, Colorado, Illinois, and Utah), the increase in the proportion of the State's population aged 65-plus was 0.5 percent or less in the 8-year period. The remaining States had larger increases.

SUMMARY: PERCENT OF STATE'S POPULATION AGED 65-PLUS, 1978

Under 8.0 (3)—Alaska, Hawaii, Utah.

8.0–8.9 (6)—Colorado, Maryland, Nevada, New Mexico, South Carolina, Wyoming.

9.0–9.9 (8)—Delaware, Georgia, Idaho, Louisiana, Michigan, North Carolina, Texas, Virginia.

10.0–10.9 (9)—Alabama, California, District of Columbia, Illinois, Indiana, Montana, New York, Ohio, Washington.

11.0–11.9 (11)—Arizona, Connecticut, Kentucky, Minnesota, Mississippi, New Hampshire, New Jersey, Oregon, Tennessee, Vermont, Wisconsin.

12.0–12.9 (9)—Kansas, Maine, Massachusetts, Nebraska, North Dakota, Oklahoma, Pennsylvania, Rhode Island, West Virginia.

13.0–13.9 (4)—Arkansas, Iowa, Missouri, South Dakota.

Over 17.0 (1)—Florida.

DISTRIBUTION AMONG THE STATES

The older population tends to be distributed among the States in the same general pattern as the total population except that there is a slightly greater concentration of older persons in some of the larger States. In the accompanying table by State rank order, at the points where the States in the total population column and the 65-plus population column match exactly, the percentages are as follows:

States	All ages		65-plus	
	Percent of United States	Cumulative	Percent of United States	Cumulative
California	10.3	10.3	9.4	9.4
New York	8.2	18.5	8.8	18.2
Texas, Pennsylvania, Illinois, Ohio, Michigan, Florida	29.5	48.0	30.8	49.0
New Jersey	3.4	51.4	3.4	52.4
Massachusetts	2.6	54.0	2.9	55.3
North Carolina, Indiana, Virginia, Georgia, Missouri, Wisconsin, Tennessee, Maryland, Minnesota, Louisiana, Washington, Alabama, Kentucky, Connecticut, South Carolina, Iowa, Oklahoma, Colorado, Oregon, Mississippi, Arizona, Kansas, Arkansas	38.6	92.6	37.8	93.1
West Virginia	.9	93.5	.9	94.0
Nebraska	.7	94.2	.8	94.8
Utah, New Mexico, Maine, Rhode Island	2.1	96.3	1.9	96.7
Hawaii, Idaho, New Hampshire, Montana, South Dakota, District of Columbia, Nevada	2.5	98.8	2.3	99.0
North Dakota, Delaware, Vermont	.8	99.6	.8	99.8
Wyoming, Alaska	.4	100.0	.2	100.0

RESIDENT POPULATION AGED 65-PLUS, BY STATE, 1970 AND 1978

State	Number		Percent increase		Percent of all ages		State rank[3]					
							Number		Percent increase		Percent of all ages	
	1970[1]	1978	1960–70	1970–78	1970	1978	1970	1978	1960–70	1970–78	1970	1978
Total, 51 States	19, 972, 330	24, 053, 950	21.1	20.4	9.8	11.0						
Alabama	324, 263	408, 377	24.7	25.9	9.4	10.9	21	19	16	16	30	27
Alaska	6, 800	9, 964	27.9	26.5	2.3	2.5	51	51	11	6	51	51
Arizona	160, 881	268, 713	79.0	67.0	9.1	11.4	35	31	1	2	34	19
Arkansas	236, 700	293, 191	22.0	23.9	12.3	13.4	28	28	21	22	3	2
California	1, 791, 615	2, 242, 727	30.9	25.2	9.0	10.1	2	1	9	17	36	34
Colorado	187, 014	232, 173	18.8	24.1	8.5	8.7	33	33	24	20	38	45
Connecticut	287, 520	347, 499	19.1	20.9	9.5	11.2	26	26	23	26	27	22
Delaware	43, 649	55, 071	22.6	26.2	8.0	9.5	48	48	20	15	42	38
District of Columbia	70, 318	72, 633	2.4	3.3	9.3	10.8	41	45	51	51	32	28
Florida	985, 266	1, 509, 809	78.2	53.2	14.5	17.6	7	3	2	3	1	1
Georgia	365, 326	472, 528	26.4	29.3	8.0	9.3	17	16	15	11	42	40
Hawaii	43, 983	66, 336	51.3	50.8	5.7	7.4	47	46	4	4	50	50
Idaho	67, 417	87, 296	16.3	29.5	9.5	9.9	44	42	29	10	27	35
Illinois	1, 088, 744	1, 206, 332	12.2	10.8	9.8	10.7	4	6	40	46	24	29
Indiana	491, 659	563, 577	10.8	14.6	9.5	10.5	12	12	45	40	27	31
Iowa	349, 213	378, 1[illegible]	6.9	8.3	12.4	13.1	19	22	49	49	2	3
Kansas	265, 329	296, 907	10.8	11.9	11.8	12.6	27	27	46	44	7	8
Kentucky	335, 919	388, 018	15.1	15.5	10.4	11.1	20	21	35	37	21	24
Louisiana	305, 009	370, 434	27.0	21.5	8.4	9.3	23	23	12	25	39	40
Maine	114, 134	132, 718	7.6	16.3	11.5	12.2	36	36	48	32	9	11
Maryland	298, 212	369, 718	32.3	24.0	7.6	8.9	25	24	8	21	45	43
Massachusetts	633, 384	699, 997	11.3	10.5	11.1	12.1	10	10	43	48	10	12
Michigan	749, 081	867, 027	18.0	15.7	8.4	9.4	8	8	25	36	39	39
Minnesota	407, 456	463, 320	15.4	13.7	10.7	11.6	15	18	33	41	14	18
Mississippi	221, 133	268, 995	17.0	21.6	10.0	11.2	30	30	27	24	22	22
Missouri	558, 374	629, 412	11.4	12.7	11.9	13.0	11	11	42	43	6	4
Montana	68, 479	81, 171	5.1	18.5	9.9	10.3	43	43	50	29	23	33
Nebraska	182, 625	202, 302	11.3	10.8	12.3	12.9	34	35	41	46	3	6
Nevada	30, 780	55, 231	70.4	79.4	6.3	8.4	49	47	3	1	49	47
New Hampshire	78, 084	96, 852	15.8	22.8	10.6	11.0	39	40	31	23	19	25

See footnotes at end of table.

RESIDENT POPULATION AGED 65-PLUS, BY STATE, 1970 AND 1978—Continued

State	Number		Percent increase		Percent of all ages		State rank [2]					
							Number		Percent increase		Percent of all ages	
	1970 [1]	1978	1960–70	1970–78	1970	1978	1970	1978	1960–70	1970–78	1970	1978
New Jersey	693, 503	824, 489	24. 4	18. 9	9. 7	11. 3	9	9	17	28	25	20
New Mexico	70, 205	103, 605	37. 7	47. 6	6. 9	8. 5	42	38	5	5	48	46
New York	1, 951, 331	2, 094, 681	15. 8	7. 3	10. 7	11. 8	1	2	31	50	14	15
North Carolina	411, 880	550, 280	32. 7	33. 6	8. 1	9. 9	14	13	7	8	41	35
North Dakota	66, 159	78, 226	13. 3	18. 2	10. 7	12. 0	45	44	36	31	14	13
Ohio	993, 119	1, 124, 794	11. 2	13. 3	9. 3	10. 5	5	7	44	42	32	31
Oklahoma	298, 674	356, 988	20. 1	19. 5	11. 7	12. 4	24	25	22	27	8	9
Oregon	225, 756	285, 462	23. 5	26. 4	10. 8	11. 7	29	29	19	14	13	16
Pennsylvania	1, 266, 508	1, 460, 554	12. 7	15. 3	10. 7	12. 4	3	4	37	38	14	9
Rhode Island	103, 836	120, 464	16. 1	16. 0	10. 9	12. 9	37	37	30	34	12	6
South Carolina	189, 842	257, 895	26. 8	35. 8	7. 3	8. 8	32	32	13	7	46	44
South Dakota	80, 274	89, 370	12. 5	11. 3	12. 1	13. 0	38	41	[illegible]	45	5	4
Tennessee	382, 021	477, 892	24. 0	25. 1	9. 7	11. 0	15	15	18	18	25	25
Texas	987, 505	1, 264, 444	32. 9	28. 0	8. 8	9. 7	6	5	6	13	37	37
Utah	77, 047	101, 911	29. 4	32. 3	7. 3	7. 8	40	39	10	9	46	49
Vermont	47, 326	54, 943	8. 6	16. 1	10. 6	11. 3	46	49	47	33	19	20
Virginia	364, 156	467, 789	26. 6	28. 5	7. 8	9. 1	18	17	14	12	44	42
Washington	320, 394	300, 664	15. 4	25. 1	9. 4	10. 6	22	20	33	18	30	30
West Virginia	193, 717	222, 661	12. 5	14. 9	11. 1	12. 0	31	34	38	39	10	13
Wisconsin	470, 634	545, 787	17. 4	16. 0	10. 7	11. 7	13	14	26	34	14	16
Wyoming	30, 076	35, 578	16. 6	18. 3	9. 1	8. 4	50	50	28	30	34	47

---

[1] Corrected for errors in numbers of centenarians.

[2] States ranked in decreasing order; State with largest quantity is ranked 1.

Source of data: Bureau of the Census (published and unpublished). Estimates and computations supplied.

XXIX

RESIDENT POPULATION, TOTAL OF AGE 65-PLUS, STATES IN RANK NUMBER ORDER, 1978

	Total, all ages				65-plus				
			Percent				Percent		
Rank	State	Number (thousands)	Distribution	Cumulative	State	Number (thousands)	Distribution	Cumulative	Rank
1	California	22, 294	10.3	10.3	California	2, 243	9.4	9.4	1
2	New York	17, 748	8.2	18.5	New York	2, 095	8.8	18.2	2
3	Texas	13, 014	6.0	24.5	Florida	1, 510	6.3	24.5	3
4	Pennsylvania	11, 750	5.4	29.9	Pennsylvania	1, 461	6.1	30.6	4
5	Illinois	11, 243	5.2	35.1	Texas	1, 264	5.3	35.9	5
6	Ohio	10, 749	4.9	40.0	Illinois	1, 206	5.1	41.0	6
7	Michigan	9, 189	4.2	44.2	Ohio	1, 125	4.7	45.7	7
8	Florida	8, 594	3.9	48.1	Michigan	867	3.6	49.3	8
9	New Jersey	7, 327	3.4	51.5	New Jersey	824	3.4	52.7	9
10	Massachusetts	[illegible], 774	2.6	54.1	Massachusetts	700	2.9	55.6	10
11	North Carolina	5, 577	2.6	56.7	Missouri	629	2.6	58.2	11
12	Indiana	5, 374	2.5	59.2	Indiana	564	2.3	60.5	12
13	Virginia	5, 148	2.4	61.6	North Carolina	550	2.3	62.8	13
14	Georgia	5, 084	2.3	63.9	Wisconsin	546	2.3	65.1	14
15	Missouri	4, 860	2.2	66.1	Tennessee	478	2.0	67.1	15
16	Wisconsin	4, 679	2.1	68.2	Georgia	473	2.0	69.1	16
17	Tennessee	4, 357	2.0	70.2	Virginia	468	1.9	71.0	17
18	Maryland	4, 143	1.9	72.1	Minnesota	463	1.9	72.9	18
19	Minnesota	4, 008	1.8	73.9	Alabama	408	1.7	74.6	19
20	Louisiana	3, 966	1.8	75.7	Washington	401	1.7	76.3	20
21	Washington	3, 774	1.7	77.4	Kentucky	388	1.6	77.9	21
22	Alabama	3, 742	1.7	79.1	Iowa	378	1.6	79.5	22
23	Kentucky	3, 498	1.6	80.7	Louisiana	370	1.5	81.0	23
24	Connecticut	3, 099	1.4	82.1	Maryland	370	1.5	82.5	24
25	South Carolina	2, 918	1.3	83.4	Oklahoma	357	1.5	84.0	25
26	Iowa	2, 896	1.3	84.7	Connecticut	347	1.4	85.4	26
27	Oklahoma	2, 880	1.3	86.0	Kansas	297	1.2	86.6	27
28	Colorado	2, 670	1.2	87.2	Arkansas	293	1.2	87.8	28
29	Oregon	2, 444	1.1	88.3	Oregon	285	1.2	89.0	29
30	Mississippi	2, 404	1.1	89.4	Mississippi	269	1.1	90.1	30
31	Arizona	2, 354	1.1	90.5	Arizona	269	1.1	91.2	31
32	Kansas	2, 348	1.1	91.6	South Carolina	258	1.1	92.3	32
33	Arkansas	2, 186	1.0	92.6	Colorado	232	1.0	93.3	33
34	West Virginia	1, 860	0.9	93.5	West Virginia	223	0.9	94.2	34
35	Nebraska	1, 565	0.7	94.2	Nebraska	202	0.8	95.0	35
36	Utah	1, 307	0.6	94.8	Maine	133	0.6	95.6	36
37	New Mexico	1, 212	0.6	95.4	Rhode Island	120	0.5	96.1	37
38	Maine	1, 091	0.5	95.9	New Mexico	104	0.4	96.5	38
39	Rhode Island	935	0.4	96.3	Utah	102	0.4	96.9	39
40	Hawaii	897	0.4	96.7	New Hampshire	96	0.4	97.3	40
41	Idaho	878	0.4	97.1	South Dakota	89	0.4	97.7	41
42	New Hampshire	871	0.4	97.5	Idaho	87	0.4	98.1	42
43	Montana	785	0.4	97.9	Montana	81	0.3	98.4	43
44	South Dakota	690	0.3	98.2	North Dakota	78	0.3	98.7	44
45	Dist. of Columbia	674	0.3	98.4	Dist. of Columbia	73	0.3	99.0	45
46	Nevada	660	0.3	98.8	Hawaii	66	0.3	99.3	46
47	North Dakota	652	0.3	99.1	Nevada	55	0.2	99.5	47
48	Delaware	583	0.3	99.4	Delaware	55	0.2	99.7	48
49	Vermont	487	0.2	99.6	Vermont	55	0.2	99.9	49
50	Wyoming	424	0.2	99.8	Wyoming	35	0.1	100.0	50
51	Alaska	403	0.2	100.0	Alaska	10	....	100.0	51

Source of data: Bureau of Census (published and unpublished). Computations supplied.

Exhibit B

INCOME AND EXPENDITURES, 1972–73

Approximately every 10 years, the Bureau of Labor Statistics collects detailed data on income and expenditures from a national sample of economic units (families and unrelated individuals) based in part on "diaries" and in part on household interviews. While the original purpose is to examine the validity of the consumption patterns and weights used in the Consumer Price Index computations, the surveys provide extremely significant data on a national basis of the sources and amounts of income, the holdings and returns on financial assets, and expenditures for consumption and other purposes. Further, the data may be cross-classified by the characteristics of the units in the sample.

The following, analytical tables show the data (annual averages for 1972–73) classified by the age of the family head (all ages, under 65, and 65-plus) with the term "family" applied to both kinds of economic units, the members of a traditional family living in a household and an unrelated individual living alone or with nonrelatives. Part A shows the characteristics of these "families." Parts B and C show the detailed data on income and expenditures summarized in the earlier text but also shows the proportion of "families" reporting such an income or expenditure item.

Most of the data are from published sources but the computation of the under-65 columns, the distributions, and the indices (the "percent of under 65" column is an index based on "under-65=100" were supplied by the author.

FAMILY INCOME AND EXPENDITURES, BY AGE OF HEAD CONSUMER EXPENDITURE INTERVIEW SURVEY, 1972-73

A. FAMILY CHARACTERISTICS

Item	All ages	Under 65	65-plus	
			Annual average	Percent of under 65
Number of families (thousands)	71, 220	56, 970	14, 250	25
1-person families	16, 761	10, 218	6, 543	64
Percent of total families	24	18	46	256
FAMILY CHARACTERISTICS				
Average:				
Size	2. 9	3. 2	1. 7	53
Income before taxes	$11, 419	$12, 701	$6, 292	50
Income after taxes	$9, 731	$10, 728	$5, 764	54
Age of head	48	42	73	194
Children under 18	1. 0	1. 2	0. 1	8
Persons 65 plus	0. 3	(1)	1. 3	(2)
Automobiles owned	1. 3	1. 4	0. 8	57
Percent distribution by:				
Housing tenure:				
Owners	59	57	66	116
Renters	37	38	32	84
Not reported	4	5	2	40
Race of head:				
White	89	89	91	102
Black	10	10	8	80
Other	1	1	1	100
Education of head:				
1 to 9 years of schooling	21	15	46	307
9 to 12 years	43	46	30	65
12 plus years	29	32	16	50
None or not reported	6	6	8	133
Automobile ownership: Own 1 plus	80	86	58	67

[1] Less than half the smallest quantity that can be shown.
[2] Not applicable.

XXXI

[illegible]. INCOME, BY SOURCE, TAXES, ASSETS, AND LIABILITIES

Item	Percent reporting			Average annual amount			
						65-plus	
	All ages	Under 65	65-plus	All ages	Under 65	Amount	Percent of under 65
Money income before taxes	98.1	98.1	98.0	$11,419.16	$12,701.73	$6,291.60	50
Wages and salaries, total	78.1	89.7	31.6	8,539.60	10,294.41	1,524.05	15
Money, wages and salaries, civilians	74.8	89.7	27.3	8,475.92	10,214.25	1,526.24	15
Union dues paid	17.2	20.0	3.0	−17.53	−21.29	−2.50	12
Other occupational expenses paid	21.2	24.8	6.9	−33.57	−38.86	−12.43	32
Rent received as pay	.9	1.0	.4	9.78	10.95	5.12	47
Meals received as pay	8.6	9.9	3.5	18.82	21.80	6.90	32
Money wages and salaries, armed forces	.9	1.1	.1	70.86	88.40	.72	1
Quarters and subsistence	1.0	1.0	(1)	15.32	19.15	(1)	(2)
Self-employment income, total	12.9	13.5	10.4	875.24	993.63	401.93	40
Net income from own business	8.9	9.8	5.3	613.59	715.17	207.50	29
Net income from own farm	4.5	4.3	5.5	261.64	278.45	194.43	70
Social security and railroad income	25.0	9.5	87.0	577.61	200.56	2,085.02	1,040
Government retirement, veteran's payments, and unemployment compensation	15.2	14.4	18.6	292.65	253.19	450.40	178
Estates, trust, dividends, interest, rental income, royalties, and income from roomers and boarders, total	64.6	64.2	66.4	533.25	383.09	1,133.58	296
Rental income, royalties, income from roomers and boarders	8.6	7.6	12.7	120.87	100.90	200.71	199
Income from interest, dividends, estates, and trusts	62.7	62.6	63.3	412.38	282.19	932.87	331
Incomes from all other sources, total	68.0	72.5	50.0	600.81	576.84	696.63	121
Welfare and public assistance	6.4	5.8	9.0	107.30	108.87	100.63	92
Private pensions	5.7	2.1	20.2	129.00	48.77	449.77	922
Regular contributions for support	4.0	4.5	2.0	70.38	82.23	23.01	28
Other, including worker's compensation	61.8	69.5	31.0	294.12	336.87	123.21	37
Personal taxes, total	80.6	89.5	44.9	−1,687.93	−1,978.19	−527.51	27
Federal income taxes	75.0	85.9	31.3	−1,399.11	−1,644.64	−447.50	25
State and local income taxes	58.6	68.6	23.7	−234.05	−275.90	−66.75	24
Personal property and other personal taxes	25.6	26.5	22.1	−54.77	−57.65	−43.26	75
Other money receipts	14.0	15.0	10.2	219.41	227.38	187.56	82
Net change in assets and liabilities, total	85.5	90.6	65.1	824.23	942.02	353.31	38
Net change in assets	73.6	77.4	58.5	1,463.88	1,730.93	395.24	23
Net change in liabilities	64.4	74.9	22.5	−639.65	−788.91	−42.92	5
Goods and services received without direct expense	64.6	67.3	53.9	132.45	148.51	68.25	46
Market value of financial assets	76.0	78.0	70.9	7,094.67	5,479.73	13,611.04	246
Mortage principal paid on owned property	35.6	42.2	9.1	−301.46	−357.85	−76.02	21

[1] Less than half the smallest quantity that can be shown.
[2] Not applicable.

Source: Bureau of Labor Statistics.

C. CONSUMER EXPENDITURES

Item	Percent reporting			Average annual amount				Percent distribution			
						65-plus				65-plus	
	All ages	Under 65	65-plus	All ages	Under 65	Amount	Percent of Under 65	All ages	Under 65	Percent	Percent of under 65
Consumpton expenses, total	100.0	100.0	100.0	$9,126.73	$10,058.90	$5,400.03	54	100.0	100.0	100.0	100
Personal insurance and pensions, total	86.7	93.4	60.1	734.18	873.77	176.13	20	8.0	8.7	3.3	38
Life, endowment, annuities, income	70.9	75.7	51.9	249.11	287.19	96.88	34	2.7	2.9	1.8	62
Other personal	10.7	11.3	8.4	7.72	8.46	4.76	56	.1	.1	.1	100
Retirement and pensions	70.8	83.2	21.2	477.35	578.12	74.49	13	5.2	5.7	1.4	25
Gifts and contributions	86.6	87.3	83.9	425.70	409.69	489.72	120	4.7	4.1	9.1	222
Consumption expense, excluding personal insurance, gifts, and contributions, total	100.0	100.0	100.0	7,966.85	8,775.44	4,734.18	54	87.3	87.2	87.7	101
Food, total	99.7	99.8	99.4	1,695.56	1,830.85	1,154.67	63	18.6	18.2	21.4	118
Food at home	99.1	99.2	98.8	1,307.62	1,388.71	983.45	71	14.3	13.8	18.2	132
Food away from home, excluding trips	87.3	92.3	67.2	369.11	420.33	164.33	39	4.0	4.2	3.0	71
Meals as pay	8.6	9.9	3.5	18.82	21.80	6.90	32	.2	.2	.1	50
Alcoholic beverages	62.7	69.2	36.9	74.80	85.98	30.12	35	.8	.9	.6	67
Tobacco products	56.5	62.0	34.4	128.50	145.71	59.70	41	1.4	1.4	1.1	79
Housing, total	99.7	99.8	99.5	2,406.95	2,619.16	1,558.56	60	26.4	26.0	28.9	111
Shelter, total	97.6	98.1	95.5	1,311.24	1,440.22	795.61	55	14.4	14.3	14.7	103
Rented dwellings	39.0	41.2	30.1	571.90	626.56	353.36	56	6.3	6.2	6.5	105
Owned dwellings	63.6	62.7	67.1	718.51	788.77	437.63	55	7.9	7.8	8.1	104
Other lodging, excluding trips	7.7	8.7	3.6	20.83	24.88	4.[illegible]	19	.2	.2	.1	50
Fuel and utilities, total	90.3	90.5	89.6	409.01	425.71	342.25	80	4.5	4.2	6.3	150
Gas, total	54.6	54.6	54.5	92.86	95.18	83.57	88	1.0	.9	1.5	167
Delivered in mains	45.2	45.5	43.9	77.64	80.37	66.71	83	.9	.8	1.2	150
Bottled or tank	10.4	10.2	11.2	15.22	14.81	16.86	114	.2	.1	.3	300
Electricity	76.1	76.3	75.3	156.80	167.39	114.45	68	1.7	1.7	2.1	124
Gas and electricity combined	13.4	13.6	12.8	40.47	42.90	30.76	72	.4	.4	.6	150
Fuel oil and kerosene	20.1	19.6	22.3	51.19	50.01	55.91	112	.6	.5	1.0	200
Other fuel, coal and wood	9.1	9.2	8.9	4.97	4.22	7.95	188	.1	(1)	.1	....
Water, trash, sewerage	62.3	62.6	61.1	62.73	66.01	49.60	75	.7	.7	.9	129
Housing experiences, total	93.6	93.7	93.3	301.16	31[illegible].90	246.21	78	3.3	3.1	4.6	148
Telephone, excluding coin phones	89.5	89.9	87.9	173.10	186.11	121.10	65	1.9	1.9	2.2	116
Other, including domestic services	68.8	68.6	69.5	128.06	128.80	125.11	97	1.4	1.3	2.3	177
House furnishings and equipment, total	88.5	91.2	77.7	385.54	438.33	174.49	40	4.2	4.4	3.2	73
Household textiles	74.3	77.9	59.9	50.82	56.05	29.90	53	.6	.6	.6	100
Furniture	41.6	46.8	20.8	131.73	153.72	43.83	29	1.4	1.5	.8	53
Floor coverings	20.8	22.9	12.3	42.21	47.12	22.58	48	.5	.5	.4	80
Major appliances	31.6	34.8	18.7	89.48	100.62	44.96	45	1.0	1.0	.8	80
Small appliances	31.6	34.9	18.4	9.77	10.88	5.34	49	.1	.1	.1	100

Housewares	25.6	28.9	12.5	9.29	10.83	3.12	29	.1	.1	.1	100
Miscellaneous	49.8	54.5	31.0	52.23	59.10	24.77	42	.6	.6	.5	83
Clothing, total	99.3	99.6	98.0	647.37	736.81	289.81	39	7.1	7.3	5.4	74
Clothing, male, age 2 plus	79.5	85.5	55.5	216.09	253.20	67.72	27	2.4	2.5	1.3	52
Clothing, female, age 2 plus	88.8	90.2	83.1	308.08	345.21	159.64	46	3.4	3.4	3.0	88
Clothing, children under 2	13.6	16.6	1.7	14.47	17.57	2.08	12	.2	.2	(1)	------------
Dry cleaning and laundry	80.9	82.8	73.2	81.98	90.58	47.59	53	.9	.9	.9	100
Materials and services	62.4	65.8	49.0	26.74	30.23	12.77	42	.3	.3	.2	67
Transportation, excluding trips, total	92.5	96.1	78.1	1,578.50	1,800.83	689.43	38	17.3	17.9	12.8	72
Vehicle purchases (net outlay)	30.4	35.6	9.8	704.55	819.92	243.30	30	7.7	8.2	4.5	55
Vehicle finance charges	29.4	35.4	5.5	79.65	90.16	37.65	42	.9	.9	.7	78
Vehicle operation, total	84.5	90.2	61.9	739.34	831.94	369.17	44	8.1	8.3	6.8	82
Gasoline	83.0	88.6	60.7	347.24	395.47	154.43	39	3.8	3.9	2.9	74
Other	82.8	88.5	60.0	392.10	436.46	214.74	49	4.3	4.3	4.0	93
Other transportation	24.3	24.1	25.3	54.97	58.90	39.30	67	.6	.6	.7	117
Health care, total	96.2	95.8	97.1	473.28	479.51	448.37	94	5.2	4.8	8.3	173
Health insurance, excluding employer share	91.1	90.6	92.4	195.81	195.63	196.54	100	2.1	1.9	3.6	189
Expenses not covered by insurance	86.2	86.3	85.8	277.47	283.88	251.83	89	3.0	2.8	4.7	168
Personal care (selected)	84.2	85.7	78.4	100.22	104.78	82.00	78	1.1	1.0	1.5	150
Recreation, total	92.5	95.6	80.1	636.33	711.50	335.79	47	7.0	7.1	6.2	87
Owned vacation home	2.7	2.8	2.4	9.96	10.55	7.60	72	.1	.1	.1	100
Vacation, pleasure trips, total	62.5	67.2	43.9	249.93	263.92	193.99	74	2.7	2.6	3.6	138
Food	53.9	58.7	34.7	57.32	62.84	35.25	56	.6	.6	.7	117
Alcoholic beverages	24.7	28.3	10.3	6.96	7.95	3.01	38	.1	.1	.1	100
Lodging	35.7	39.6	20.1	41.15	41.55	39.54	95	.5	.4	.7	175
Transportation, total	60.0	64.8	40.7	86.50	91.97	64.62	70	.9	.9	1.2	133
Gasoline	53.1	58.9	30.1	32.03	36.07	15.88	44	.4	.4	.3	75
Other transportation	39.0	41.8	28.0	54.47	55.90	48.74	87	.6	.6	.9	150
All expense tours	7.7	8.0	6.7	35.08	33.61	40.96	122	.4	.3	.8	267
Other vacation expenses	38.9	43.7	19.7	22.92	26.00	10.60	41	.3	.3	.2	67
Boats, aircraft, and wheel goods	15.3	18.2	3.8	83.59	99.59	19.61	20	.9	1.0	.4	40
Other recreation, total	90.4	94.2	75.1	292.86	337.45	114.59	34	3.2	3.4	2.1	62
Television	15.8	17.5	8.9	46.54	51.24	27.73	54	.5	.5	.5	100
Other	89.7	93.7	73.7	246.31	286.19	86.86	30	2.7	2.8	1.6	57
Reading materials	84.0	86.0	76.2	47.72	51.98	30.68	59	.5	.5	.6	120
Education, total	24.2	29.3	3.9	102.53	124.65	14.10	11	1.1	1.2	.3	25
Private	10.4	12.6	1.6	62.05	75.49	8.31	11	.7	.8	.2	25
Public	16.7	20.2	2.6	40.48	49.16	5.79	12	.4	.5	.1	20
Miscellaneous	67.7	71.1	54.3	75.08	83.62	40.95	49	.8	.8	.8	100

---

[1] Less than half the smallest quantity that can be shown.

Source: Bureau of Labor Statistics.

96TH CONGRESS
1st Session
SENATE
REPORT
No. 96-55

PART 1

DEVELOPMENTS IN AGING: 1978

MARCH 30, 1979.—Ordered to be printed
Filed under authority of the order of the Senate of March 29, 1979

Mr. CHILES, from the Special Committee on Aging,
submitted the following

REPORT

together with

ADDITIONAL VIEWS

[Pursuant to S. Res. 375, and S. Res. 376, 95th Cong.]

CHAPTER I

ADJUSTING TO AN "AGING POPULATION"

Challenges to current practices, attitudes, and public policies related to this Nation's work and retirement patterns intensified during 1978.

A successful legislative effort[1] which, in effect, raised mandatory retirement age from 65 to 70 and abolished it completely for most Federal employees served notice that a push for total abolition is likely to continue.

Governmental and other studies were directed more and more at probable trends, problems, or opportunities which could accompany the mounting average age of our population, culminating in what the Secretary of Health, Education, and Welfare describes as the probable reappearance of this century's postwar "baby boom" as a "senior boom" early in the 21st century.[2]

---

[1] Public Law 95-256—the Age Discrimination in Employment Amendments of 1978—makes other potentially far-reaching changes affecting older workers. See part F, section VIII, of this report for additional details.

The Senate Committee on Aging held theme-setting hearings on "Retirement, Work, and Lifelong Learning"[3] in July 1978. At a later hearing,[4] Chairman Frank Church identified several recurring themes advanced by witnesses and said they should be considered simultaneously, rather than separately:

> We hear a great deal, for example, about pension problems, but very little is done in the way of relating them to work force issues.
>
> Another example, this committee has given a great deal of attention over the years to older worker problems, and we have been concerned about educational opportunity during the later years, but we haven't usually thought of these subjects together, and we should.[5]

Senator Pete Domenici, ranking minority member of the committee, said:

> Our ability to look at the "big picture" regarding employment, retirement, and continuing education should enable us to develop a hearing record that will benefit other committees, executive agencies, State and local governments, as well as the private sector. America will meet and overcome these challenges, which is the mark of a great civilization.[6]

Among the recurring themes from the first round of hearings were:

> We are ill-prepared, in terms of public policy and private sector response, for the vast changes that can be expected with the increase in the proportions of older persons in our population along with a decrease in the percentage of younger persons within labor force limits.
>
> We have no real national retirement policy; we have many sources of income for life in the later years, but none—including social security—generally does the entire job. We have to think more clearly about the appropriate "mix" of social security and other sources of retirement income.
>
> We fail to recognize fully the economic and social consequences of earlier and earlier retirement, now and even more so in the future.
>
> That the probable, forthcoming total abolition of mandatory retirement will cause stubborn, work-related questions—such as retraining to combat job skill obsolescence—to emerge with new clarity and urgency.
>
> Finally, the challenges ahead, while at times boggling, are nevertheless rich in promise of success, if we keep our heads and if we also question past habits of thought and action.[7]

---

[2] In testimony before this committee at hearing on July 17, 1978, in Washington, D.C. Hearing was printed after this report was prepared, therefore no page numbers are available.

[3] July 17, 18, 19, 1978, Washington, D.C.

[4] Sept. 8, 1978, Washington, D.C.

[5] Opening statement, July 17, 1978.

[6] Opening statement, July 17, 1978.

[7] From Senator Church's opening statement, Sept. 8, 1978.

THE INFLATION FACTOR

Another theme expressed with some frequency was the harsh impact of inflation, not only on individual persons and their families, but upon retirement income systems. A national organization for older persons summed it up:

> Elevated rates of persistent inflation hold the gravest consequences for the elderly. Not only do their personal financial arrangements suffer, but the income maintenance and income support arrangements of the Federal, State, and local governments are forced to meet with increasingly severe problems in funding the payments, which must be indexed to offset higher prices. These financing problems are often partly met by throwing the losses of inflation on pensioners. This may be done by ignoring inflation, by partially ignoring inflation in making only partial pension adjustments that do not offset fully the effect of inflation—a common practice at the State and local level—or by making adjustment for inflation long after the fact. The private sector follows suit; ad hoc adjustment in pension payments are made irregularly, if at all. Most employers make no provision out of current expenses for meeting the future costs of making such adjustments in pension payments largely because there is no way that the size and cost of those adjustments can be known in advance.[8]

[*For additional discussion of inflation and retirement income, see chapter II.*]

I. THE TRENDS

Demographers can anticipate a "senior boom" early in the next century because all of those who will reach age 65 then have been born; their actuarial future can be forecast with reasonable accuracy. But overall proportions of "young" and "old" can fluctuate markedly if (1) the birth rate pattern of today, far lower than it was in the two decades after World War II, rises significantly or if (2) longevity for older persons increases by even a few years. Nevertheless, the most commonly accepted assumptions held today foresee a dramatic increase in the proportion of elderly and an equally striking reduction in the proportion of young.

One observer has described this graying process as "an upheaval comparable to the immigrant tide in the late 19th and early 20th centuries and the migration of blacks to the North after World War II."

A. THE STATISTICAL UNDERPINNINGS

Bureau of the Census Chief Statistician Jacob Siegel recently gave a fresh reappraisal[9] of census studies on prospective changes in the size and structure of the elderly population.

---

[8] From statement by National Retired Teachers Association/American Association of Retired Persons submitted for Sept. 8, 1978, hearing.

[9] "Consequences of Changing U.S. Population. Demographics of Aging." May 24, 1978, at a joint hearing before the Select Committee on Population and the Select Committee on Aging of the U.S. House of Representatives (pp. 76-121). For a more comprehensive treatment, see U.S. Bureau of the Census, "Demographic Aspects of Aging and the Older Population in the United States," by Mr. Siegel, Current Population Reports, Series P-23, No. 59 (rev.), May 1976.

Warning against assumptions that people become members of a "homogeneous" group upon reaching age 65,[10] Mr. Siegel made these points:

Population 65 and over is expected to grow at only about half the rate of the past quarter century, but this growth will still be considerable:

	Percent increase			
	65 and over	65–74	75–84	85 and over
Period:				
1950–76	85	67	104	233
1976–2000	39	23	57	91
2000–20	42	61	15	27

The 65-plus numerical increase will be from 23 million in 1976 to 32 million in 2000 and 45 million by 2020, as indicated in detail in table 1:

TABLE 1.—PERCENT OF THE TOTAL POPULATION AT THE OLDER AGES, BY SEX: 1950 TO 2020

[Estimates and projections as of July 1. Based on totals including Armed Forces overseas. See text for explanation of Series I, II, and III]

					Projections [1]					
					1980		2000		2020	
Age and sex	1950	1960	1970	1976	II	Range I–III	II	Range I–III	II	Range I–III
ALL RACES										
Both sexes:										
60 years and over	12.1	13.2	14.1	15.0	15.6	15.5–15.7	16.1	14.8–17.1	21.8	17.9–25.0
65 years and over	8.1	9.3	9.9	10.7	11.2	11.1–11.3	12.2	11.3–12.9	15.5	12.7–17.8
70 years and over	4.8	5.8	6.4	6.8	7.3	7.2–7.4	8.7	8.0–9.2	10.0	8.2–10.2
75 years and over	2.6	3.1	3.7	4.1	4.2	4.2–4.3	5.5	5.1–5.9	5.9	4.8–6.7
85 years and over	0.4	0.5	0.7	0.9	1.0	1.0–1.0	1.4	1.3–1.5	1.6	1.3–1.7
Male:										
60 years and over	11.8	12.4	12.6	13.1	13.6	13.5–13.7	13.8	12.7–14.7	19.3	15.7–22.3
65 years and over	7.7	8.5	8.5	9.0	9.3	9.3–9.4	10.0	9.2–10.7	13.2	10.7–15.2
70 years and over	4.5	5.2	5.3	5.5	5.8	5.7–5.8	6.8	6.2–7.2	8.0	6.5–9.2
75 years and over	2.3	2.7	3.0	3.1	3.1	3.1–3.2	4.0	3.7–4.2	4.3	3.4–4.9
85 years and over	0.3	0.4	0.5	0.6	0.7	0.6–0.7	0.8	0.8–0.9	0.9	0.8–1.1
Female:										
60 years and over	12.5	14.1	15.6	16.8	17.6	17.4–17.7	18.3	16.9–19.3	24.1	20.0–27.5
65 years and over	8.6	10.0	11.2	12.3	13.0	12.9–13.1	14.3	13.2–15.1	17.8	14.7–20.3
70 years and over	5.2	6.3	7.5	8.1	8.8	8.7–8.8	10.5	9.7–11.1	12.0	9.9–13.6
75 years and over	2.8	3.5	4.4	5.0	5.3	5.3–5.3	7.0	6.5–7.4	7.4	6.1–8.4
85 years and over	0.5	0.6	0.9	1.2	1.4	1.4–1.4	2.0	1.9–2.1	2.3	1.9–2.6

[1] Base date of projections is July 1, 1976.

Source: U.S. Bureau of the Census, "Current Population Reports," Series P–25, Nos. 311, 519, 614, 643, and 704.

---

[10] Herman Brotman, consultant to this committee for the "Retirement, Work, and Lifelong Learning" hearings and other matters, also makes that point: "The older population is not a homogeneous group, nor is it static. Every day, approximately 5,000 Americans celebrate their 65th birthday. Every day, approximately 3,600 persons aged 65-plus die. The net increase is about 1,400 a day, or half a million a year, but the 5,000 'newcomers' each day are quite different from and have lived through a quite different life history than those already 65-plus and are worlds apart from those already centenarians who were born shortly after the Civil War." (From 'Developments in Aging: 1977,' p. XVI, Senate Committee on Aging, April 1978.)

Difficult as it is to project proportions of 65-plus persons to overall population because of possible fertility fluctuations, the following provides a reasonable picture of future possibilities:

Year:	Percent
1976	10.7.
1980	11.2 (11.1–11.3).[1]
1990	12.2 (11.7–12.6).
2000	12.2 (11.3–12.9).
2010	12.7 (11.1–13.9).
2020	15.5 (12.7–17.8).
2030	18.3 (14.0–22.1).
2040	17.8 (12.5–22.8).

[1] On Bureau of Census fertility tables to come.

The proportion of those 75 years and older as part of the 65-plus group was about 38 percent in 1976 and will probably be 45 percent in 2000, and may fall back to about 38 percent again as larger cohorts born in the high fertility period following World War II enter the younger segment of the group (65 to 74). Rates of increase for women in the 75-plus group will be greater than for men in the same group, but the tremendous differences in the growth rates of the sexes seen in the last decades will not be repeated:

Sex and period	Percent increase			
	65 and over	65–74	75–84	85 and over
Male:				
1950–76	60	51	69	159
1976–2000	36	24	55	69
2000–20	45	63	17	25
Female:				
1950–76	108	82	135	286
1976–2000	41	22	58	101
2000–20	39	60	14	28

Note: For each sex for the 1976–2000 period, growth rates progress upward with increasing age.

THE SECRETARY'S APPRAISAL

Health, Education, and Welfare Secretary Joseph Califano, leadoff witness at this committee's July 17 hearing, linked such projections with what he called four dramatic and seemingly inevitable trends about the aging of America.

First:

> Life expectancy has increased almost 10 years since 1940. In 1940, the average life expectancy at birth was about 63½ years, lower than social security's retirement age of 65. Today, life expectancy is 69 for men, 77 for women. Three-quarters of the population now reaches age 65; once there, they live on the average for another 16 years, to age 81. As we contemplate the year 2050, we are told that life expectancy will increase only another 3 years for men and 4 for women. *And we must remember that biomedical advances have consistently ren-*

> *dered recent projections of life expectancy too low.* [Emphasis added.]

Second: Predicting the transformation of the baby-boom group of this century to the senior-boom people of the next, the Secretary said:

> In 1940, roughly 7 percent of the total population was 65 and over; today, the proportion is 11 percent—more than 24 million people. After 2010, the elderly percentage will not just increase: it will soar . . .
>
> By the year 2030, nearly 1 in 5 Americans—55 million citizens—will be 65 or older. And the composition of the older population is changing also. In 1940, only 30 percent of older citizens were 75 or older; by the year 2000 they will comprise 45 percent of the elderly—more than 14 million people.

Third:

> Ironically, while people are living longer, they are retiring earlier. Thirty years ago, nearly one-half of all men 65 and over remained in the work force. Today, among people 65 and over, only 1 man in 5, and 1 woman in 12, are in the work force. *There is no indication that this trend to earlier retirement will cease.* This confronts us with some serious questions concerning not only the cost of providing retirement income, but the quality of life for many citizens who may spend 20 years, or even longer, in retirement. [Emphasis added.]

Fourth:

> The ratio of active workers to retired citizens will change dramatically over the future: from 6 to 1 today to only 3 to 1 in 2030. This ratio is important because it suggests how many active workers are available to support programs for the elderly. We can estimate this ratio by comparing the number of citizens 65 and over to those 20–64. This is rather crude, since some persons over 65 are not retired, and many people age 20 to 64 are not workers. But the historical changes in this ratio are extraordinary nonetheless: In 1940, there were 9 citizens age 20 to 64 for every citizen 65 or over; today, it is 6 to 1; by 2030 it will be only 3 to 1.

B. QUESTIONS ABOUT THE "DEPENDENCY RATIO"

As acknowledged by Secretary Califano, the so-called dependency ratio—or proportion of workers to nonworkers—can be challenged on a number of grounds: it provides only a "crude" indicator of potential proportions.

Another witness, Dr. Harold Sheppard,[11] said that conventional dependency ratios use an arbitrary and imprecise definition of "working age" population, assuming that all persons 20 or 21 to 59 years old are actually working as a support base for the nonworking young and old, and that they are all working full time.

---

[11] Dr. Sheppard, senior research fellow at the American Institutes for Research since March 1975, and director of the Center of Work on Aging, is coauthor (with Sara E. Rix) of "The Graying of Working America: The Coming Crisis of Retirement-Age Policy" (1977). He is consultant to this committee on the "Retirement, Work, and Lifelong Learning" study and on other matters. The above excerpts are from his testimony at the July 17, 1978, hearing.

He added:

> Another problem with using simply a dependency ratio approach is that it tells us nothing about costs, which, after all, is what this fuss is all about. It is quite possible to find, for example, that a dependency ratio might go up—more nonworking persons per 100 workers over time—but costs could nevertheless go down. The dependency ratio might remain the same over the next four or five decades, but costs could go up. In other words, the sample arithmetical body-count approach tells us nothing about costs.

THE BIOMEDICAL DIMENSION

Sheppard described recent biomedical developments as "the new feature in the story." As recently as 1970, demographers and biostatisticians were expecting about 6 million persons of age 80 and over by the year 2000. But recent projections, reflecting improvements in mortality rates of older adult groups now put that total at close to 8 million. Sheppard added:

> If we continue to pursue the goal of improving the health conditions of preelderly Americans—and no one, I hope, can challenge that goal—we must be prepared to cope with the full consequences of successful outcomes. And one of those outcomes is an increase in life expectancy among older adult men and women, which results in greater increases in the numbers of persons becoming 80 and older.

Focus on the Family: As did Secretary Califano, Sheppard said that persons of 80 and over are more likely to require care of one or more chronic illnesses than others in the 65-plus group. He agreed with the Secretary's emphasis on helping families to provide care when appropriate. But he asked whether the children of the very old, over the next few decades, can be expected to provide direct services to their elderly relatives or pay directly for those services. He provided the following "quantitative clues" as to the human side of the emerging problems:

> Back in 1960, I first became interested in how large a percentage of Americans 60–64 had parents still alive, as one indication of the responsibilities of those on the verge of retirement, or already in their early retirement years. The most convenient way of estimating that percentage is to take the total population 80 and over, and divide that by the size of the population 60 to 64 years old—as a rough approximation of the number of very old parents and relatives that the young-old have. In 1960, according to such an approach, there were 34 very old persons for every 100 persons 60–64. By 1970, this ratio had increased to 46. By 1980, it will probably be 52. By the end of the next decade—by 1990—we

> can expect to find 63 very old persons for every 100 60–64, and by the end of the century, the proportion will rise to 79.
>
> Keep in mind that in 1970, the proportion was only 46. Compare that proportion to the one expected by the year 2000—79—assuming, of course, that no further reduction in the mortality rates of older adult Americans takes place. Further reductions mean a higher proportion of the young-old with very old family members.

Such statistics raise what Sheppard described as a number of critical policy questions:

> For example, can we really expect an increasing proportion of Americans in their early sixties to take care of their elderly relatives, especially if they themselves are retired? They might have more time to provide such care, but what about the expenses involved, particularly in relation to retirement income? If we do witness an increase or stabilization of the labor force participation rate of persons 60–64, will they, because of the time factor, be able directly to provide those services?
>
> Finally, assuming that much of the support costs for this population of persons 80 and older—nearly 80 million by the year 2000—will be borne by the total working population, might this not constitute a motive on the part of the under-60 working population to keep older workers in the labor force longer than is currently the case as one way of distributing over a wide population and sharing the collective expenditures?
>
> My concern over the past several years is that, as a Nation, we can assure our very old fellow citizens—those about 80 or older—of a quality of retirement life that will not put them or the Nation to shame. But that goal requires a strong economic base which implies a large enough working population. I am suggesting here that we need now to consider the need to include in that working population substantial proportions of those age groups that are now defined as "retirable," or of pensionable age.

II. THE RETIREMENT POLICY THICKET

Four major concerns related to current retirement practices emerged at the hearings:

—The lack of a national policy in the face of helter-skelter costly retirement income systems.

—Very uneven distribution of economic protection for older persons who have left the work force, with special reference to the need for establishing sensible relationships between social security retirement benefits and other forms of income in later life.

—Problems of minority groups.

—A clearcut and perhaps accelerating trend toward earlier and earlier retirement at just the time that demographic and economic pressures appear to push in a contrary direction.

A. In Search of a National Policy

Congress, in its debates about amendments which changed current mandatory retirement practices, dealt only tangentially with the overall retirement policy of this Nation.

The debate, triggered by the 1978 amendments to the Age Discrimination in Employment Act (*For additional discussion of Public Law 95–256, the Age Discrimination in Employment Amendments of 1978, see chapter XI, part VIII*, focused attention on the growing commitment to retirement income expenditures and what is generally regarded as the inadequate factual and conceptual base needed to understand present realities and future implications.

Senators and witnesses at the July and September hearings criticized present policy gaps and contradictions. Secretary of Labor Ray Marshall, for example, called for a review of the entire income support system for the elderly:

> The role of the private pension system and its relation to social security should be studied with the aim of providing more adequate income support to the retired. Special attention must be given to the effects of inflation on private pension benefits. The soundness of the government-financed programs also should be carefully examined.[12]

A New York Times article reached a similar conclusion:

> . . . overall, the steps that have been taken to correct shortcomings and abuses in both the private pension and the social security systems are generally conceded to be no more than aspirins to relieve the immediate symptoms of a much deeper affliction: the lack of a national retirement policy. In fact, nobody seems to know how the various plans affect one another or how the system as a whole affects the economy.[13]

THE SOCIAL SECURITY SHARE

Social security was described by Secretary Califano as dominating the pension landscape—not simply in size, but in reliability. He also said: "It is, quite simply, probably the grandest and most successful social experiment of our age." The National Council of Senior Citizens, critical of what they call "alarms and scare stories, questioning the financial soundness of the social security system," added:

> Given all the uncertain guesses which prophets use to foretell the future, the anticipated problems may be exaggerated. But again, the social security system is not the problem; it is the answer! Those persons born during this baby-boom period will be with us early in the next century and they will be in need of a system of income maintenance when they reach retirement age. Obviously, though it sometimes seems to be overlooked, they would be here with their needs even if we did not have a social security system.[14]

---

[12] In testimony on July 18 at hearings cited in footnote 3.

[13] "Life in a Rose-Covered Cottage Isn't Rosy on $2,485 a Year," by Philip Shabecoff, June 25, 1978.

[14] From hearing cited in footnote 4.

The "old age" portion of OASDHI (the formal name for social security is old-age, survivors, disability, and health insurance) was operating on the following scale in 1978, according to SSA reports:

BENEFICIARIES (FEBRUARY 1978)

Retired workers	17, 928, 926
Wives and husbands	2, 965, 932
Children	668, 340
Total retired workers and dependents (out of a total of 34,137,276 for all of OASDHI)	21, 563, 198

SOCIAL SECURITY MONTHLY RETIREMENT BENEFITS

(July 1978, including 6.5 cost-of-living adjustment)

Maximum benefit for worker retiring in 1978 at age 65	$489. 70
Maximum benefit for worker retiring in 1978 at age 65 with spouse 65 years old	734. 60
Minimum benefit for worker retiring at age 65	121. 80
Minimum benefit for worker retiring at age 65 with spouse 65 years old	182. 70
Average benefit, retired worker alone	254. 00
Average benefit, retired couple both receiving benefits	432. 00
Average benefit, aged widow	239. 00

Approximately 110 million persons paid contributions, or payroll taxes, to social security in 1978. In 1982 the total will be 122 million. The following table gives estimated outlays for cash benefits of OASDI for the next decade:

Calendar year	Income	Disbursements	Net increase in funds	Funds at end of year	Funds at beginning of year as a percentage of disbursements during year
1977 [1]	82. 0	87. 3	−5. 3	35. 9	47
1978	91. 8	97. 1	−5. 2	30. 6	37
1979	105. 8	107. 8	−2. 0	28. 6	28
1980	118. 6	119. 3	−. 7	27. 9	24
1981	138. 5	131. 1	7. 4	35. 3	21
1982	154. 5	143. 6	10. 9	46. 2	25
1983	169. 1	156. 0	13. 0	59. 2	30
1984	181. 9	168. 9	13. 0	72. 2	35
1985	205. 3	181. 9	23. 4	95. 7	40
1986	222. 0	195. 4	26. 6	122. 2	49
1987	237. 9	209. 8	28. 2	150. 4	58
1988	255. 6	225. 1	30. 5	180. 9	67

[1] Figures for 1977 represent actual experience.

Note: Totals do not necessarily equal the sum of rounded components.

The 1978 Board of Trustees report gives this assessment of the status of old-age, survivors, and disability trust funds over the next few years:

> The Social Security Amendments of 1977 have restored the financial soundness of the cash benefit program over the short- and medium-range periods, beginning in 1981 and greatly improved the long-range actuarial status. The additional financing provided by the 1977 amendments in calendar years 1978–80 prevents the assets of the combined trust funds from falling below 21 percent of expenditures—for the equivalent of about 2½ months of expenditures—at the beginning

of 1981 under the intermediate assumptions. The recently appointed Advisory Council on Social Security is studying the long-range financial status of the social security program and will report their findings and recommendations in 1979. In view of these considerations, and the short time that has elapsed since the enactment of the 1977 amendments, the Board recommends that no action be taken to change the financial arrangements of the social security system at this time. The Board believes that there is ample time to await the Advisory Council's report before making any proposals to change the financing provisions in present law. Nonetheless, the Board also recommends that the likelihood of significant long-range deficits be recognized in all current planning and in all proposals that would modify the system.

THE OTHER SOURCES

Important as social security is, it does not work in isolation. Secretary Califano listed other sources:

—The supplemental security income program reached about 23 million aged beneficiaries, about 70 percent of whom also received social security.

—About $50 billion is paid out in benefits each year by "68 different retirement plans in the Federal Government, more than 6,000 State and local pension plans, and thousands of private plans." The Secretary added: "Of all new social security retirees, fully half have other pension income."

—Help is also provided through tax expenditures: tax breaks accorded to pension plans and social security income, and for elderly taxpayers, will total more than $19 billion in fiscal 1978.

—Finally, there are private savings, which provide an estimated $15 to $20 billion in income to retirees.

Secretary Marshall, discussing the growth of private pension plans, said:[15]

> In 1960, $1.7 billion in private retirement benefits were paid to about 1.8 million beneficiaries; by 1975, $14.8 billion were paid to 7 million beneficiaries. An estimated 47 percent of wage and salary workers in the private sector are currently participating in retirement plans.

---

[15] Secretaries Califano and Marshall appear to differ about the financial status of private pensions. The HEW Secretary, saying that the "integrity of employer pension plans is open to serious question," asserted that unfunded liabilities for private plans is roughly $200 billion. He added: "Ten of the largest industrial corporations in America have unfunded pension liabilities equal to a third or more of their net worth; seven of them have unfunded liabilities which exceed the aggregate market value of the common stock." Asked by Senator Pete Domenici what he meant by the use of the word "unfunded," Secretary Califano replied: "I use the term 'unfunded' to mean funds that are not here today to cover all the liabilities that those systems have incurred. The Secretary also said: "Obviously, they all represent conscious decisions to rely on current income from various sources. I do think these numbers raise very serious questions about the extent to which this committee should look at the need for legislation to assure that individuals who are relying on those unfunded pension plans for their retirement years will indeed be placing their reliance with security." Asked on the following day for comment on the degree to which private pension funds are fully funded, Secretary Marshall said: "We have just completed a special study of it because using different actuarial methods you can reach totally different conclusions about whether or not the pension funds are fully funded. There is no question that it is a serious problem, but I think it requires very careful thought and it is easy to exaggerate it; it is easy to use some actuarial methods that make it look like the funds are not as sound as they really are in terms of being able to be paid off."

The Labor Secretary also identified several groups of workers whose retirement income falls below a Bureau of Labor Statistics budget standard for living costs in urban areas:

> First, many persons do not qualify for a private pension. Such pension plan coverage generally is concentrated on those persons with higher than average wages during their working lives. As a result, those workers who are forced to rely solely on social security benefits tend to be low- and moderate-wage workers. Moreover, *most private pension plans lack protection against inflation.* [Emphasis added.]
>
> Second, some of those who file for reduced benefits before 65 are in effect forced to do so. It is more difficult for a person in their 60's to find another job once they become unemployed. A Social Security Administration study of persons filing for reduced benefits at age 62 *found that one-fifth of the men and one-third of the women had been unemployed more than 12 months prior to applying.* [Emphasis added.]

QUESTIONS ABOUT THE MIX

Senate Committee on Aging members, after analysis of testimony and studies, will decide in 1979 on issues which will receive special attention in its study of "Retirement, Work, and Lifelong Learnings."

Among the issues posed by witnesses about the relationship of social security payments to other forms of retirement income, were several by Secretary Califano:

—A basic question is what the ratio should be between income earned before retirement and income thereafter.

—[For new social security retirees aged 65, this ratio today stands at about 47 percent.] Questions exist about those at the "top" and the "bottom" of the social security scale. "Today," said the Secretary, "social security benefits are wholly exempt from taxes. It seems at least open to discussion whether a wealthy lawyer, doctor, or business executive with a $40,000 pension should receive tax-free social security benefits." Turning to the low-income social security beneficiaries, the Secretary said that their ratio between contributions and benefits is not fixed, and now stands at 61 percent to help make benefits more adequate; whereas for high-income recipients it falls to 35 percent. He asked whether we wish a broadening of the supplemental security income which focuses income only on the low end of the income scale.

—As to private pensions, he asked whether we wish to continue to encourage "the creation of this layer on top of social security by providing substantial tax benefits for contributions to pension plans, and he asked whether "we are comfortable with a system in which some retirees pile up the maximum social security benefits on top of generous pensions, while other retirees have no pension income and find social security barely enough to get by on."

—And finally, should social security coverage be extended to all employees, including public and nonprofit workers? He added: "Income maintenance policy should not be a game with complex rules, winners who get windfalls and losers who get nothing; it should be a rational system meeting definable human needs."

Additional questions or proposals made during the hearings for modifications of the present social security-private pension relationship:

> "The Federal Government should define the minimum—and perhaps maximum—parameters of what constitutes a suitable retirement benefit and how it will be funded and made available, as well as control of abuses and policing of implementation."
>
> —Stanley Babson,[16]
> *Financial consultant.*

> "A special consumer price index for the elderly should be constructed; cost-of-living adjustments under social security should be given twice a year instead of once."
>
> —National Council of Senior Citizens.

> "The social security system . . . should be transformed into a national pension program which has earnings replacement as its dominant purpose. The minimum floor-of-income function would be the responsibility of a revamped SSI program." Other features would include the introduction of actuarially increased benefits for those electing to work after age 65 and postpone applying for benefits—a fixed 3 percent annual increase, which becomes effective in 1982, is already in law—and "pay-as-you-go" financing from payroll taxes with an additional general revenue mechanism to act as economic safety nets protecting the program from high rates of inflation and unemployment; and elimination of the social security earnings test, "a severe work disincentive." [17]
>
> —National Retired Teachers Association/American Association of Retired Persons.

> "Almost unanimously, witnesses asked for broadening of work opportunities for older employees in order to reduce claims for early retirement benefits under social security or to postpone such payments after age 65. Typical was this statement: 'Clearly, there needs to be a stronger Federal commitment to promoting employment opportunities for middle-aged and older workers.' "
>
> —National Council on the Aging.[18]

---

[16] Mr. Babson, who testified on July 19, is a former senior vice president of finance and administration for the Technicon Corp. He is author of "Fringe Benefits: The Depreciation, Obsolescence, and Transcience of Man" (1974).

[17] The social security "earnings limitation" or "retirement test" sets an amount of $4,500 yearly in 1979 to beneficiaries 65 to 71 years old ($3,480 for those under 65) of earnings possible without any loss of social security benefits. NRTA-AARP disputes arguments that elimination of the retirement test would be costly and would benefit high income beneficiaries, in particular. "We firmly believe," says the NRTA-AARP statement, "that as an economic matter, the earnings test already costs society more than its worth and will cost even more in the future. In addition, the elderly detest it." Their estimates of "cost" are based on "lost production or of the [illegible] to the government in foregone income and social security taxes" that would be paid if older persons were not discouraged from working by the reduction in social security benefits. The NCSC statement takes an opposing view: "The National Council of Senior Citizens is opposed to abolishing the retirement test completely on the grounds that to do so would be financially irresponsible and severely inequitable to most beneficiaries." The NCSC position is spelled out in a booklet called "The Retirement Test in Social Security," issued in May 1976 and written by Nelson H. Cruikshank, then NCSC president.

[18] In Statement at hearing cited in footnote 4

B. THE TREND TO EARLY RETIREMENT

Secretary of Labor Marshall reported that there is a decided downturn in the age at which Americans are retiring. In 1950, 46 percent of men aged 65 and over were in the labor force. In 1965, it was 28 percent. And today, it stands at 20 percent. Lower participation rates are also evident for the 55–65 age groups, as indicated in the following table:

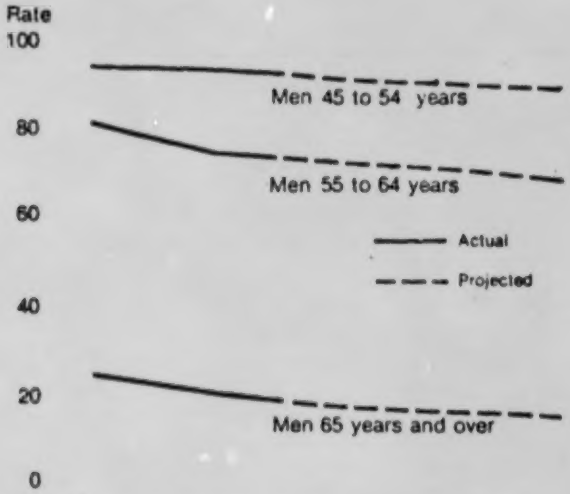
LABOR FORCE PARTICIPATION RATES FOR OLDER AGE GROUPS, BY SEX, SELECTED YEARS, 1950–78

Age group and year	Men	Women
50 to 54 years:		
1950	90.5	30.8
1960	92.0	45.9
1970	91.5	52.4
1978	89.7	54.5
55 to 59 years:		
1950	86.7	25.9
1960	87.7	39.7
1970	86.8	47.8
1978	82.9	48.6
60 to 64 years:		
1950	79.4	20.6
1960	77.8	29.4
1970	73.2	36.4
1978	62.0	33.1
65 to 69 years:		
1950	59.7	12.0
1960	44.0	16.5
1970	39.3	17.2
1978	30.1	14.9

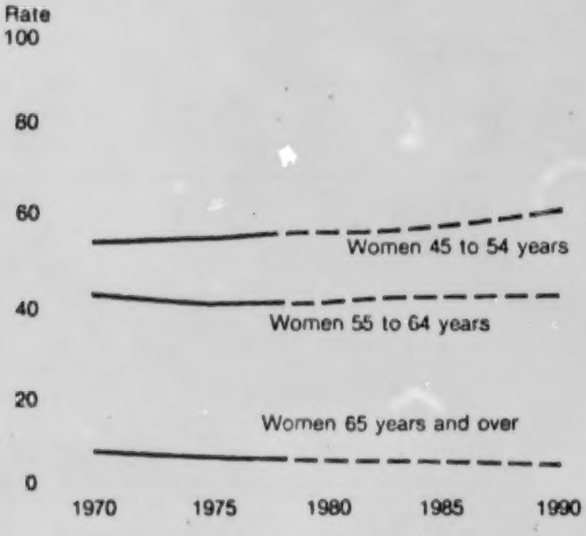
Source: Bureau of the Census, 1970 Census of Population, Employment Status and Work Experience, table 2 for 1950, 1960, and 1970 data. The 1978 data are from the Bureau of Labor Statistics annual averages from the 1978 Current Population Survey.

The labor force participation rate for women 50 to 59 years old has increased steadily since 1950, although more moderately since 1970. However, for women 60 or older, the rate has declined since 1970, after rising steadily during the two preceding decades.

The downward trend in middle-aged and older men's labor force participation is expected to continue...



...while women's participation will rise until age 65 and then drop moderately.



Source: U.S. Department of Labor.

A PROBLEM OR AN ACHIEVEMENT?

> "Until fairly recently, 'early retirement'—before age 65—has been a symbol of social progress, especially when it offers a release with dignity from many years in undesirable working conditions, or when the worker's health is failing."
>
> —Page 97, Employment and Training Report of the President, 1978.

As Secretary Califano observed, the traditional concept of retirement was support for workers who have reached old age and can no longer work. But a new view of retirement sees it as "a reward not necessarily related to old age; simply a reward for a certain period of work—typically 20 to 30 years." But this approach to retirement, said the Secretary, is expensive: "It is born of the rich choices that affluence, without inflation, seemed to offer in the past years."

Similar concerns about the present and future costliness of retirement below the traditional age of 65 were voiced by other witnesses.

Charles Merin, representing the National Association of Retired Federal Employees, asked at the September 8 hearing:

> Can we afford early retirement? The inactive or retired population is growing at a significantly faster rate than the active or working population and by the year 2020 45 percent of the population will be either under 18 or over 65 and, given the present configuration of laws, who is going to produce the gross national product of this country?

The National Council on the Aging, in a statement submitted by Robert Ahrens of the Chicago Mayor's Office for Senior Citizens and Handicapped, stated:

> The economic effects of early retirement can be devastating. . . . It is true that many workers look forward to retirement and appreciate company policies that allow early retirement at minimally reduced pension benefit levels. But, it is not true that all older workers enjoy being "put out to pasture," nor should they. Consider the fact that, on the average, a man reaching his 65th birthday could expect to live 13.4 years longer; a woman, 17.5 years.
>
> Over the years, those who retired on seemingly adequate pension and social security benefits will see their purchasing power diminish as the cost of living climbs.[19]

In addition, Mr. Ahrens said, those who are forced to retire early often do so under the worst of circumstances:

> Work-related problems often become more severe for older adults because of the age discrimination inherent in American society. The recent economic recession severely affected the employment status of older workers; the unemployment rate for those over 55 more than doubled during 1974 and has only very slowly begun to decrease. Once out

---

[19] The statement added: "The overwhelming majority of private pension plans pay fixed retirement benefits, with no provision for adjustment due to inflation. If inflation averages 7 percent a year, the purchasing power of fixed pensions will be reduced by 50 percent in 10 years. For example, a fixed retirement income of $200 a month will be worth about $100 a month in 10 years and about $50 a month in 20 years if inflation is 7 percent a year."

> of a job, the older worker traditionally has a more difficult time in finding a new one. Too often, he is forced into early retirement after months and sometimes years of "job searching."

Former Bureau of Labor Statistics Commissioner Ewan Clague[20] described early retirement as causing two inflationary pressures:

> One is the shortened duration of contributions; perhaps 30 years of work to age 50, plus a lengthened duration of benefits, age 50 to age 80. The other is the combination of full-time earnings and early retirement benefits (when the "retiree" begins a new career after a pension begins). Furthermore, the new earnings may produce a second retirement benefit.

Dr. Sheppard, Director of the Center on Work and Aging of the American Institutes of Research, said:

> . . . early retirement costs the general economy something, and the benefits, such as the alleged increase in job opportunities for the younger population, might not exceed those costs. Indeed, the real resource costs involved—including the reduction of an economy's potential output due to early retirement patterns—must be reckoned with. It is even possible that the standard of living of the remaining working population would have to be lower. After all, the increased cost of early retirement has to be paid from a smaller national product.

A potent trend: Whatever arguments may be raised against it, early retirement nevertheless remains a powerful force in the labor marketplace. A report[21] issued in November 1978 by the Conference Board concluded: "The move toward early retirement is so pronounced that the average retirement age in some firms is now below 60." The survey of 41 personnel officers at major U.S. companies found that the combined total of a company pension and social security payments may make it unattractive for many workers to continue employment, and it adds:

> Virtually all of those surveyed oppose special increases in company pensions or buyouts in order to spur people 65 and over to retire. Generally, it is felt that the natural trend toward early retirement is so strong that it is not needed.

The United Auto Workers reported in November that nearly 45,000 auto workers opted for pensions after 30 years of service from 1971 through 1977. The largest surge came in October 1978, when the benefit level hit $700 a month.[22]

C. MINORITY CONCERNS

Dr. Dolores A. Davis, executive director of the National Caucus on the Black Aged, noted at the September 8 hearing that little had been said in July about differing retirement patterns of the older black population.

---

[20] In testimony presented on July 18, 1978.

[21] "The Ban on Mandatory Retirement at 65: Management Responses," information bulletin No. 46, the Conference Board, 845 Third Avenue, New York, N.Y.

[22] Detroit Free Press, Nov. 19, 1978, "Bumper Crop of 30-and-Outers," by Ralph Orr.

She said that the greatest fear of national organizations representing the black elderly is that growing concern about the rising costs of retirement in this Nation could produce legislation to raise the age of eligibility for social security benefits. Her statement cited a National Center on Black Aged study which revealed that:

- —Black males aged 45 and over suffer from unemployment rates that are nearly twice as high as the rates for their white counterparts.
- —Black males aged 45 and over do not participate in the job market as readily as their white counterparts.
- —Elderly poverty rates are at least 2½ times as high for elderly blacks than those for whites.
- —Older black workers are handicapped in finding jobs because of their substantially lower levels of education than whites.

What is often called "retirement" among older black persons, Dr. Davis added, may often be poor health or economic status or other involuntary pressures. Among Dr. Davis' recommendations was Federal action to reduce differences which characterize black and white unemployment rates.

A National Indian Council on Aging statement,[23] submitted by Larry Curley, noted that of approximately 89,000 Indians who are 60 years or older, nearly 75 percent may have incomes at or below the poverty level. In the year 2000, 25 percent of the total Indian population will be 50 years or older. This will be approximately half a milion—an increase of almost 800 percent:

> Most will be educated at the ninth grade level living on income derived from their past earnings—mostly lower paid employment throughout their earning years, which would not produce the maximum allowable income from the social security programs. Some will benefit from private pension programs, but most will not benefit from these programs since the life expectancy of Indian persons born in 1950 was approximately 50 years of age. . . . Retirement to that group of "eligibles" will mean a time of searching and developing a definition of existence. It will mean a time of isolation since most of the young people will be in the urban areas pursuing their occupations. As a result, the traditional natural system of cooperation and assistance will have eroded to mere romantic reminiscence (this even seems to be the case in 1978).

Carmela G. Lacayo, executive director of the Asociacion Nacional Pro Personas Mayores (National Association for Spanish Speaking Elderly,[24] also looked to the future elderly and asked for action in today's job market:

> . . . according to 1978 census data, almost 42 percent of the Hispanics in the United States are 18 years old or younger. Demographers agree that the highest fertility ages are between the ages of 20 to 29. Since the Hispanic community is just on the threshold of the highest fertility aged period,

---

[23] Submitted in conjunction with hearing cited in footnote 4.

[24] In a statement submitted in conjunction with the hearing cited in footnote 4.

> given Hispanics larger family size, it is clear that the Hispanic community will significantly increase over the next two decades by propagation alone. Thus, the policies and plans formulated today, in anticipation of the aged of tomorrow, must consider a significantly expanded Hispanic elderly population . . . policy does not operate in a vacuum. Government policy on retirement, employment, and lifelong learning will affect all of society's attitudes and opinions about work and growing old in America. Such policies will have a profound effect on all the institutions of society. And unless steps are taken to affect the realities of minority group workers today, the prospects of retirement and lifelong learning will be meaningless for minority group workers tomorrow.

(*For additional discussion of minority issues, see chapter XI, part I.*)

III. POTENTIAL ROLE OF BROADENED WORK OPPORTUNITIES

If early retirement is unwanted—and becomes more so in the future for many older workers because of inflation and other factors—can appropriate work opportunities be developed and made accessible to those who may wish to continue employment?

Secretary Marshall offered this prediction:

> . . . the prospect of an expanding older population with a stable or declining younger population also has its optimistic aspects. As the current low birth rate makes itself felt in the labor markets of the future, the skills and contributions of older workers will be increasingly sought. Employers will find themselves competing for the services of older workers, possibly bidding up wages and accommodating their desires for more flexible work schedules. As employers take a positive approach in which they recognize the worth of their older employees, the ultimate result will be wider opportunities, and more cooperative relations among different age groups.

The Secretary said employers should ideally provide "a full menu of options" for the older employee, including: Continued full-time work, regular part-time, temporary callback, consulting relationships, and community work.

Formidable difficulties, as described in an employment report issued by the Department of Labor in 1978, stand in the way of an improved lot for older workers:

—Emerging industries may recruit or require workers, typically from younger age groups, but more than half of the employed men aged 45 and over in 1970 were concentrated in declining or slow-growth industries.

—Limited educational attainment hampers many older workers.

—Current population survey data for 1976 . . . show that over 60 percent of the 45- to 54-year-old male nonparticipants in the labor force had left their last jobs due to ill health or disability;

less than 15 percent of them reported any intention to seek another job.

—Studies of older worker job performance tend to disapprove the prevailing belief that older people are less effective workers than younger workers, but "there is some truth to the proposition that older workers are more reluctant than younger ones to undergo training for new skills. Frequently, this attitude may be the result of a psychological concern that they may fail."[25]

In addition, there continues to be ample evidence that negative attitudes toward older workers affect acceptance of their skills and services. Dr. Bernard I. Forman, Washington representative of the National Gray Panthers, challenged age-based discrimination:[26]

> We see age-ism as having four basic dimensions: stereotyping, segregation, paternalism, and victim-blaming. They tend to overlap and reinforce each other and provide convenient alibis for social evasions and calloused exploitation. Young and old alike suffer from their common, characteristic failure to recognize that people remain individuals throughout life—and have individual needs, desires, and problems regardless of age. Categorizing people as "too immature," "overqualified," "too impetuous," or "set in their ways" ignores the infinite variety of human nature and human experience.

A. The Positive Side: What Is Already Happening

National organizations which serve as contractors for the senior community service employment program—SCSEP—(formerly title IX, now title V of the Older Americans Act) gave examples of the usefulness and adaptability of this program, which, in 1978, provided part-time work opportunities for 47,500 persons of age 55 or above. (*For additional information about the SCSEP program and older worker problems, see chapter XI, part VIII.*)

Senator Lawton Chiles said he has observed the fulfillment and enthusiasm of participants in such employment program—as well as the Foster Grandparent program—and he added:[27]

> It looks to me that this is one of the most attractive options that we have. We generally, I think, are getting more for our money. We pay these people part-time salaries for their services. They are very satisfied with that; they are looking for part-time income. I don't know of a better return we are getting for our dollar, and I just certainly hope that the Department would continue the broadening of these programs.

Secretary of Labor Marshall said he agreed with Senator Chiles' appraisal of SCSEP and described it as "a very good program from all perspectives."

A new provision of the Comprehensive Employment and Training Act, advanced by Senators Chiles and Domenici, also came under discussion. (See chapter XI, part VIII for details.) Said Senator Chiles in explaining the concern about services for elderly workers under CETA:

---

[25] Summarized from pp. 90–97, "Employment and Training Report of the President," transmitted to the Congress in April 1978.

[26] Submitted in conjunction with hearing cited in footnote 4.

[27] At July 18 hearing cited in footnote 3.

> Many of us feel that the older workers are currently underserved by CETA, and I wanted to call that section to your attention.

The Secretary replied:

> We think we need the targeted programs like Green Thumb that you have mentioned, but we also need to encourage CETA to employ older workers. It now provides jobs for about 100,000 older workers in fiscal year 1977, and we think that, as the overall level of unemployment declines, the participation by older workers in the system should and probably will increase.

B. The Private Sector

Secretary Marshall suggested that the Committee on Aging "may wish to consider further hearings to publicize efforts by private employees in offering such [flexible] arrangements, thus encouraging others to follow this example."

Examples of private incentives to encourage older workers were grouped by the NCOA under four headings:

1. *Employers could voluntarily end mandatory retirement:*

Among the already numerous and diverse private and public employers who have ended mandatory retirement are Tektronix, Inc., United States Steel, Hamrick Mills, Gold Kist Agricultural Cooperative, Paddock Publications, Steinway & Sons, the city of Chicago, the State civil service in Maine, Bankers Life & Casualty Co., and most public and private employers in California, where a new State law abolished compulsory retirement last year. Bankers Life has been without mandatory retirement for 40 years and reports that its experience has been "consistently favorable throughout a variety of economic cycles and stages of company growth."

To determine functional capacity to perform work tasks, 4,000 individuals were screened during 1970 to 1975 in a GULHEMP (general physique, upper extremities, lower extremities, hearing, eyesight, mentality, and personality). Findings were matched to minimum job requirements.

"Not one of the employees who were employed after being matched for a specific job was involved in an industrial accident or a workman's compensation case," said the NCOA statement.

The United States Steel non-age-related retirement policy requires employees to pass annual physical examinations closely related to their jobs. Often when a worker seems to be falling short on one job, management joins with the local union to find another more suitable job.

2. *Employers could institute more flexible work arrangements to allow older employees to make a more gradual transition into retirement:*

At the very least, employers should consider systems of phased-in retirement, whereby workers might be encouraged to shift to part-time jobs before entering full retirement.

Senator Charles Percy told Secretary Marshall on July 18:

> My own industrial experience shows that when we introduced a program of compulsory retirement at age 68, we did it on a phased-in basis. We required beginning at age 65 a paid vacation plan plus an extra month the next year, plus 2 months the next year, plus 3 months the next year, so they phased out with a program of 15 weeks of counseling with the families 5 years prior to retirement, on various phases of adjustment to the retirement. . . . I think 15 to 16 other companies followed us later. . . .

Two workers may be able to share a full-time job where part-time work does not contribute to management's goals.

Retired employees could be used as a company's temporary work pool instead of relying on inexperienced outsiders.

The permanent part-time work force of America is now the fastest growing segment of the employed. It has increased in the past 15 years by 40 to 50 percent. The concept of part-time work, which includes job-sharing, has largely been avoided in the general economy because the American system of unemployment insurance excludes those persons from their benefits and because work-sharing is thought to increase employers' costs. However, in the older worker category, work-sharing can become an important alternative to retirement by providing additional income and utilizing talents and skills developed which would be of disservice to the entire society if placed on the shelf.

3. Employers could offer retraining for new careers or encourage continuing education on the part of their employees:

Example: An employment program such as the Erie Guild (Erie, Pa.) combines the flexibility of part-time employment with a new career thrust for skilled retired workers. In this program, begun in 1971, highly skilled sheetmetal workers, drill press operators, and welders were put to work tutoring on a 1-to-1 basis unemployed and unskilled workers to fill the type job that the retiree once held. An agreement was reached with the union leaders whereby trainees (who are paid under CETA) reaching production level would be hired, but not automatically at the level of skill for which they had been trained. After a short period of time, they became members of the union.

C. FEDERAL GOVERNMENT AS A MODEL EMPLOYER?

Secretary Marshall recommended that the Federal Government, as a major employer, "should become a leader in offering flexible work schedules and wider career options for older workers." He cited DOL support for "flexitime" and part-time employment in the Federal Government.

(*See chapter XI, part VIII for additional details on enactment of this legislation.*)

Alan K. Campbell, Chairman of what was then the U.S. Civil Service Commission, appeared before the committee on July 19 to discuss, among other things, the implementation in the provision of the Age Discrimination in Employment Act Amendments of 1978 abolishing age 70 for mandatory retirement in the Federal Service. (Over the past few years, the Federal work force has remained relatively static at about 2.7 million persons; in 1977, only 1,773 were mandatorily retired; the average age of Federal retirees was 58.3.) The CSC (now the Office of Personnel Management and the Merit System Protection the new law, which was described by Campbell as probably having the new law, which was described by Campbell as probabbly having "minimal" impact. He added, however, that the removal of mandatory retirement can be expected to affect performance evaluation programs in at least two ways:

> The first impact is upon the manager who, seeing his staff growing older, begins to interpret the performance evaluation guidelines more strictly in evaluating middle-aged and elderly employees to provide an alternative to mandatory retirement.
>
> The second impact is upon the employees whose job skills become outdated over time and must be renewed or changed.

To develop a "fair and effective evaluation program for all employees," CSC is developing the following components:

—Positions described by skills and abilities;
—Fair and effective performance appraisals;
—Self-analysis and career planning;
—Modified work arrangements, including part-time, special assignments, voluntary reassignment to lower position and pay.

Mr. Campbell added:

> To retire or terminate an older employee would require evidence that would stand up in court that the employee was not performing properly, so that the employer can demonstrate that the separation was not based on age alone. To obtain this evidence, agencies would have to make their programs for evaluating employees more objective. All ages must be evaluated on the same basis. Evaluating an older employee under more severe standards would amount to age discrimination.

One problem cited by Campbell was the ceilings under which a part-time employee who worked 2 hours a week counted the same as one who worked 39 hours a week. He explained:

> Because of the limited number of ceiling spaces, managers frequently do not want to use their allocation for less than the number of staff hours available. This obviously discourages the hiring of true part-time workers.

Questions about CSC policies: A representative* of the National Association of Retired Federal Employees, testifying at the September 9 hearing, challenged Commissioner Campbell's statement that elimination of the age 70 mandatory separation provision would not have a major impact on the Federal civil service:

> Mandatory retirement served as a significant psychologic[illegible] disincentive to performance by older workers. With no hope of remaining on the job past mandatory retirement age, worker self-esteem and productivity most certainly diminished.

---

* Charles L. Merin, then NARFE legislative representative.

The witness also urged the CSC to make a greater effort to provide reliable preretirement counseling:

> Some basic data dramatize the urgency of this problem. In 1965, there were approximately 728,000 Federal annuitants and survivors throughout the United States; today that figure exceeds the 1.5 million mark. With Federal employees retiring at the rate of approximately 80,000 per year, the need for competent and readily accessible preretirement counseling services is clear.

IV. LIFELONG LEARNING

> ". . . policymakers with a lifelong learning perspective can help to close the gap between the learning and work-lives of individuals by improving the work-related experience available through the educational system, by improving the learning opportunities available at the workplace, and by encouraging linkage between both systems to support continual human development and life transitions."
>
> —"Lifelong Learning and Public Policy,"
> HEW-DOL Report, February 1978, p. vii.

Learning opportunities of all kinds—including those oriented to work, adjustment in retirement, of cultural development—will be needed to help cope with likely demands which will accompany the aging of our population.

This conclusion, gaining widespread concurrence among committee witnesses and others, nevertheless took differing forms and differing priorities.

Education for today's elderly: The National Council of Senior Citizens said that the partially literate elderly are underrepresented in the federally funded adult basic education program.

The NCSC statement added:

> We are particularly concerned that public and privately funded ventures into what is sometimes called citizen education (an effort to provide citizens with the information and skills needed to use our democratic political process to better their lives) tend to overlook the aged and concentrate their attention upon the young and the middle-aged. But the aged—not our members at least—do not retire from citizenship.
>
> It is noteworthy that the National Institute of Education has at this time no program to study the learning needs and wants of the aged.
>
> The blunt truth is that today's aged have financed a vast and expensive publicly funded educational bureaucracy which gives a very low priority to providing appropriate learning opportunities for them.

Another aspect of education was related to what one witness on September 8 called self-improvement activities:

> Skills such as managing money, planning adequate diets, knowing appropriate exercise programs, preventive health mechanisms, dealing with bureaucracy, once learned usually are effective throughout the life cycle; once mastered, these skills have lasting power. We need to know something about the transmission of these skills throughout the life cycle and we need also to learn whether and how skills in one area are transferrable to another area.[29]

Education for recycling of skills: A representative of the private sector put the case most directly at committee hearings for more widespread concern about systematic retraining to prevent obsolescence of worker skills.

Stanley M. Babson, Jr., a financial consultant with experience in medium-sized and large firms, said that accountants generally think of workers as a cost—an overhead expense, a charge against operations. He added:

> Frequently ignored is the extent of the investments that corporations make in an employee. It costs to attract him, to recruit him, sometimes to relocate him, to train him, and to maximize his productivity and momentum and, finally, to terminate him. All too often, these peripheral costs are lost sight of superficial decisions can be made as to the temporary advantage to the corporation of an employee motivated by cost reduction per se.[30]

Babson suggested that more information be sought about an employee's motives for retirement:

> Is he tired? If so, why not scale down by degrees instead of all or nothing? It is certainly a cheaper approach than full-scale retirement. Is he bored? If so, why not a new assignment after a certain number of years? Isn't it conceivable that a person could be recycled into another type of activity entirely? If wage level is a barrier, let the new wage apply and again draw down a supplemental wage from a "semiretirement fund."

NRTA/AARP also emphasized economic functions of lifelong learning:

> In the coming year, the Institute of Lifetime Learning will be assessing the work/education field to identify realistic options for the reeducation and retraining of the employed middle-aged and older workers. This option might include job-sharing, job transition, returning to earlier careers, job reclassification, and skill renewal. Once the various options have been assessed, the institute, in cooperation with various educational and corporate institutions, will assist in the development and implementation of training materials and curricula.

Among Dr. Sheppard's recommendations was one calling for the Departments of Labor and Health, Education, and Welfare—along with the Congress and the private sector—to take "the appropriate measures to develop expanded programs for midcareer development."

---

[29] In statement submitted by Mildred M. Seltzer, president-elect of the Association for Gerontology in Higher Education, in conjunction with hearing cited in footnote 4.

[30] In statement submitted in conjunction with July 19 hearing cited in footnote 3.

Learning for learning's sake: According to press and official accounts, a large number of older persons are attending courses at universities, evening courses at local schools or colleges, and in other learning environments. A paper prepared for the HEW lifelong learning report gave this account:

> According to a survey by the Academy for Educational Development, one out of three colleges and universities now offers learning opportunities for older persons, and 28 States have passed legislation permitting older students to enroll in regularly scheduled classes free or at reduced tuition rates. A variety of other organizations and institutions—senior centers, community schools, museums, membership groups, and libraries—have also started educational programs for older persons or have encouraged them to participate in ongoing activities. Some 100 museums, for example, now make special efforts to reach older adults.

The paper added, however, that "the elderly remain outside the mainstream of adult education because of relatively low educational attainment, on the average, and other barriers, including transportation problems and an instructional bias in favor of youth."

(See chapter XI, part VII, for additional information about educational opportunities for older persons.)

Education about aging: Attitudes toward aging are often shaped by what young persons are taught, or not taught, from the very beginning of their schooling. A representative of the Association for Gerontology in Higher Education asked these questions:

> What can we do in the earlier years of life that will encourage people to view educational organizations as appropriate resources throughout the life cycle and how can educational institutions be changed to accept education as a lifelong actuality?
>
> What are we teaching children in the primary grades about old age and aging?
>
> About work and retirement?
>
> While there are attempts to introduce curriculum content on these topics in the K through 12 grades, how effective have they been?
>
> How can you teach young children about work, retirement, and aging?
>
> Or do you?
>
> Are the curriculum materials being used to reach young children about aging doing an accurate job, or do they provide further reinforcement of existing stereotypes?
>
> How do you teach teachers about aging and the teaching of life cycle approaches?

She added:

> . . . all of these are researchable questions on which, as yet, we have little data. Answers to these questions will give

58

us some indication about the usefulness of education in achieving attitude changes.

V. THE GRAYING OF THE BUDGET: QUESTIONS

Implicit—or, at times, very explicit—concern was expressed during the Committee on Aging hearings about total Federal allotments for present and future older Americans.

The committee, in future hearings and studies, will focus on the expenditure issues and will seek expert opinions on vital issues related to public allocations related to an "aging" population. Some perspective, however, has already been provided by recent statements.

Secretary Califano, in his testimony, acknowledged the magnitude of present and probable future commitments:

> This year, six major programs for which HEW has responsibility—old age insurance, survivors and disability insurance, medicare, medicaid, supplemental security income, and black lung benefits—will pay out more than $94 billion to persons 65 and over. Another $14 billion will be paid to this group under the civil service, railroad, and military retirement programs. Still another $4 billion will go to the elderly under other programs providing housing subsidies, food stamps, social and employment services.
>
> This adds up to $112 billion—5 percent of the gross national product, and 24 percent of the Federal budget for fiscal year 1978.
>
> This is a whopping increase. Real spending under these programs in 1978 will be four times what it was in 1960, when we spent only 2.5 percent of GNP on programs for the elderly. And from only 13 percent of the Federal budget in 1960, the percentage has nearly doubled—largely due to the enactment of such major programs as medicare and medicaid, real benefit increases in social security, and other program expansions.
>
> These expenditures, large as they are, are expected to grow even more. Under the major programs I have mentioned, estimating benefits only for recipients age 65 or older, we expect real spending to more than triple: to $350 billion by the year 2010. Between 2010 and 2025, when the "baby boom" becomes the "senior boom," real spending will escalate from more than $350 billion to around $635 billion. It will constitute more than 10 percent of GNP; more than 40 percent of total Federal outlays.

The Secretary added:

> The figures, I should emphasize, are subject to the hazards that afflict all estimates. I cite them not to alarm; simply to inform. *What I have just described is a shift in the age of our population; the shift in resources that has followed is both inevitable and natural.* [Emphasis added.]
>
> Indeed, the presence in our society of a growing elderly population is as much a blessing as a cause for concern. It speaks to the success we have had as a nation in improving the health and well-being of all our citizens, in making the

> advances of the medical sciences more broadly available, and in being able to respond to the changing needs of citizens of all ages. If we are spending more on behalf of older Americans, that is only as it should be. It is one mark of the respect in which society holds the older generation.
>
> Nor is the effort we make on behalf of the elderly unrelated to our own lives. The taxes that younger workers pay on what they earn today not only assure their own futures, they make possible a better present for all generations. With medicare paying for the medical needs of elderly parents, the earnings of the young can be used for education or the downpayment on a home. We may, as family members, choose to live with different generations under different roofs, but we remain members of our families wherever we may live; the economic choices made by any one generation affect all.
>
> Indeed, "the elderly" are ourselves—and our children. The commitments we make to the elderly of tomorrow are no less than the commitments which we all make to ourselves.

The National Council of Senior Citizens, in a statement submitted at the September 8 hearings, said:

> While Government support of the aged has increased over the past 20 years, such expenditures represent only 5 percent of our gross national product. In fact, the growth of categorical programs for the aged in the past decade can be attributed to the low level of support in prior years due to wholesale discrimination against older persons in other government service and employment programs.

Dr. Robert Butler, Director of the National Institute on Aging, also has entered into the discussion of budget commitments for aging,[31] warning against regarding the elderly population as a "burden" or "drain." He asked for a broadening of the discussion to include these dimensions:

> 1. The costs of a public policy of supporting retirees reflect the public policy of forced or induced retirement. Simply put, the need for all those dollars in retirement systems might be lessened if we did not pressure people to leave the work force while they were able and willing to continue working. This does not mean forcing people not to retire, but rather to remove pressure the other way. Those who wish to claim their social security cash benefits should have no barrier to exercising their rights at any time.
>
> While a policymaker focusing narrowing on the budget impact of all those retirement systems might want to reduce benefit levels now or in the future, a wiser approach might be to consider whether we have not boxed ourselves into a budgetary corner because of nonbudgetary decisions. If

---

[31] Dr. Butler's article, "The Economics of Aging: We Are Asking the Wrong Questions," appeared in the November 4 issue of the National Journal. It was written partially in response to a Feb. 18, 1978 Journal article, "Busting the U.S. Budget—the Costs of an Aging America." The Journal has since issued other articles exploring aging issues, including a special report, "Growing Old in America," which appeared in its Oct. 28, 1978 issue. In December, the Journal conducted a 3-day conference in Washington, D.C., on the "Economics of Aging."

people were free to decide to continue working after age 65—and they continue to contribute to retirement systems—the budget could become far less menacing and far more manageable.

2. A considerable proportion of the $152.7 billion reflects the existence of illness and disability in the older population. What if the source of that illness and disability were in part related to policies of premature retirement and the stresses they may bring? What if we could identify the biomedical and socioenvironmental factors that produce the sickness and disability that prompt some people to retire? Suppose these illness factors could be minimized in some way: Would we not reduce the great sums being spent through such programs as medicare and medicaid for institutional and other services?

3. . . . while the governmental cost of the medicare program has burgeoned, the elderly now pay as much out of pocket for health care as they did before medicare began. So, the elderly do share the costs of their health services. To what extent is the increasing cost of medicare to be attributed to the elderly? To what extent is it to be attributed to the providers of services?

Cost containment is as much a pertinent issue in the rise of medicare costs as is the growth of the elderly population. The cost containment issue raises questions about social policy: Should we reduce or freeze benefits to accommodate the increased costs? Should we tighten up on cost controls and require providers to justify their spending in the light of community priorities and funding availability?

We all know that health care costs have risen much faster than the Consumer Price Index. And we know, too, that social security benefit levels at the time medicare began did not—and still do not—provide anything approaching a decent standard of living. One may argue that the social security system was not set up to be a guarantor by itself of a decent standard of living in retirement. But we know that relatively few elderly persons have any major pension to rely on, and that to be old often means to be poor. Surely, we must rethink the place of social security in the context of retirement income needs as they exist more than 40 years after the program began.

VI. CONCLUSION

A combination of factors—including inflation, growing recognition of the dramatic changes to be expected in the age structure of our population in the next half century, and growing concern about the cost of Government—have caused the Senate Committee on Aging to begin an inquiry into "Retirement, Work, and Lifelong Learning."

Our preliminary hearings and research have identified a large number of issues and suggested many others. The committee will have to be selective in choosing a manageable, yet broad-based, range of themes and individual subjects to explore and arrange in ways which will throw new light and information on matters of concern to all generations.

This task would be timely even if there were not a White House Conference on Aging scheduled for 1981. The fact that this Conference has been authorized by the Congress and endorsed by the administration lends even greater urgency to the mobilization of facts needed to obtain a proper perspective on policy issues to be decided in the future.

This committee will, therefore, maintain close contact with other factfinding units, including congressional bodies which may have already begun or are considering research of their own, in an effort to arrive at an effective information exchange which will serve several purposes, including development of a data base worthy of the forthcoming White House Conference. We acknowledge help already provided by units of the executive branch toward that end, and we will continue to seek their help.

It is clear that the aging of our population will call for boldness and clarity of thought and action. To view this process simply in terms of causing a "burden" to younger generations is to limit our will and our vision.

We look forward to new information and ideas from all who will help us as we look further into "Retirement, Work, and Lifelong Learning."

CHAPTER II

INFLATION AND RETIREMENT INCOME

Older Americans—perhaps more so than all other Americans—are sensitive to price increases, primarily because they live to a large degree on an essentially fixed income.

Many elderly persons have repeatedly emphasized to the Committee on Aging[1] that coping with the high cost of living is their most important day-to-day problem.

In recent years that struggle has intensified. From December 1958 to December 1968, the average annual increase in prices amounted to 2.3 percent. However, the average yearly inflation rate has nearly quadrupled during the past decade, to 9.1 percent.

DECEMBER TO DECEMBER PERCENTAGE CHANGE IN CONSUMER PRICE INDEX, 1948–78

[Year and percent change]

1948	2.7	1964	1.2
1949	1.8	1965	1.9
1950	5.8	1966	3.4
1951	5.9	1967	3.0
1952	.9	1968	4.7
1953	.6	1969	6.1
1954	.5	1970	5.5
1955	.4	1971	3.4
1956	2.9	1972	3.4
1957	3.0	1973	8.8
1958	1.8	1974	12.2
1959	1.5	1975	7.0
1960	1.5	1976	4.8
1961	.7	1977	6.8
1962	.7	1978	9.0
1963	1.6		

Source: Washington Post, Oct. 29, 1978, p. F1.

Ewan Clague, former Commissioner of the Bureau of Labor Statistics, warned in July 1978:

> If the 1968–78 cost-of-living increase continues into the future, the Consumer Price Index at the end of 1990 will be about 400 (double the present) and will be nearing 800 by the year 2001 (doubling again). This is *not* a forecast; it is a pro-

---

[1] For example, see "Developments in Aging: 1975 and January-May 1976," pt. 1. S. Rept. 94–998, 94th Cong., 2d sess., pp. 20–60.

> jection to show where the economy is going unless steps are taken to correct inflation, whatever may be the cost.[2]

Mr. Clague provided some examples to illustrate the impact of rising prices in the marketplace if these trends should continue:

> . . . In our home a half-gallon of milk now costs 85 cents; in 2001 it would be $3.40. A $100 man's suit would cost $400; the Metro fare in Washington would be $2, or possibly even more, because the fares aren't high enough now to cover expenses.[3]

I. RISES IN COST OF LIVING

Prices continued ominously upward in 1978, rising by 9 percent from December 1977 to December 1978. All Americans felt the impact in one form or another wherever they went: the supermarket, the doctor's office, the department store, the gas station, and elsewhere.

Limited retirement income created major problems for the elderly to absorb steep price hikes in everyday necessities. Increasingly, they found themselves confronted with difficult and sometimes impossible choices. Should they buy food for the table or necessary prescriptions to maintain their health? Should they raise the heat at home and risk driving up the utility bill or should they visit a doctor?

Increasingly, older Americans discovered that a seemingly comfortable income a few years ago bought far less in 1978. During the past 5 years (from December 1973 to December 1978) the price of goods and services jumped by nearly 50 percent (46.5 percent).

Ewan Clague noted that an elderly person's purchasing power would be cut in half in 12 years with an annual inflation rate of 6 percent. He added:

> A retired worker drawing benefits of $10,000 a year would have the purchasing power cut in half with a 6-percent inflation rate over a period of 12 years ($5,057). The following table shows the shrinking purchasing power of that pension. For this calculation, the results are rounded to the nearest dollar.

Year:	*Purchasing power*	*Year:*	*Purchasing power*
1	$10, 000	7	$6, 890
2	9, 400	8	6, 477
3	8, 836	9	6, 088
4	8, 296	10	5, 723
5	7, 798	11	5, 380
6	7, 330	12	5, 057

> At the end of 6 years the retiree would lose over one-fourth of the value of his pension ($7,330). In 9 years its purchasing power is almost down to 60 percent of the original benefit.[4]

---

[2] "Retirement, Work, and Lifelong Learning," hearing before the Senate Special Committee on Aging, Washington, D.C., July 18, 1978. Hearing was printed after this report was prepared, therefore no page numbers are available.

[3] Testimony at hearing cited in footnote 2.

[4] Written response by Ewan Clague to a question raised in connection with the hearing cited in footnote 2.

He also describes the effect of a 4-percent inflation rate on the purchasing power of an older American:

> At an inflation rate of 4 percent the retiree comes out much better.

Year:	*Purchasing power*	*Year:*	*Purchasing power*
1	$10,000	7	$7,824
2	9,600	8	7,514
3	9,216	9	7,213
4	8,847	10	6,925
5	8,493	11	6,648
6	8,153	12	6,382

> At the end of 6 years the retiree is down about 19 percent ($8,153), and at 9 years about 28 percent ($7,213). In the 12th year the loss has been over 36 percent.[5]

Mr. Clague pointed out that early retirees may be even more vulnerable to inflation, since they will probably live longer in retirement than those waiting until age 65.

> Furthermore, for early retirees 12 years may be far too low an estimate. With increasing longevity, those retiring at 62 have a reasonable prospect of about 16 years. That would result in the following shrinkage of retirement income in a period of 6 percent annual inflation.

Year:	*Purchasing power*	*Year:*	*Purchasing power*
13	$4,754	15	$4,200
14	4,468	16	3,948

> The additional years would bring a shrinkage of purchasing power to less than $4,000 in the 16th year. The retiree would by that time be approaching the poverty level.[6]

II. AREAS OF SPECIAL IMPACT ON THE ELDERLY

Compounding everything else, some of the sharpest price increases have occurred in areas where the elderly's greatest expenditures are concentrated: Housing, food, medical care, and transportation. These four items typically account for more than $4 out of every $5 in an aged family's budget.

During the past 5 years, these basic expenditures have been right at or above—and in some cases substantially above—the increase in the overall Consumer Price Index.

PERCENT OF PRICE INCREASES

	December 1977 to December 1978	December 1973 to December 1978
Consumer Price Index (all items)	9.0	46.5
Food	11.8	45.0
Medical care	8.8	61.1
Transportation	7.7	52.0
Housing	9.9	50.4
Other goods and services	6.4	44.0

Source: Bureau of Labor Statistics, Department of Labor.

---

[5] Written response by Ewan Clague to a question raised in connection with the hearing cited in footnote 2.

[6] Written response by Ewan Clague to a question raised in connection with the hearing cited in footnote 2.

Some components, such as utility charges—which are included in housing—have surged forward at a more accelerated pace—and in some cases more than twice the overall inflation rate for the Consumer Price Index. Natural gas, for example, rose by 109.2 percent during the past 5 years; home heating fuel oil No. 2 by 90 percent; and electricity, by 66.5 percent.

PERCENT INCREASES IN ENERGY COSTS

	December 1977 to December 1978	December 1973 to December 1978
Natural gas	11.2	109.1
Home heating fuel oil No. 2	7.7	82.5
Electricity	7.2	66.5
Other goods and services	7.7	40.4
Consumer Price Index (all items)	8.3	47.1

The 1977 Social Security Amendments[7] authorized a nine-member national Commission to conduct a thorough study of social security, including the need to develop a special Consumer Price Index for the elderly. The Commission is to present a full report to the President and to the Congress within 2 years after a majority of the members have been appointed.

III. IMPACT ON RETIREMENT SYSTEMS

Inflation not only erodes the purchasing power of older Americans, but it also threatens to undercut the actuarial soundness of public and private retirement systems. A seemingly insignificant rise in prices can have an enormous effect on social security, the civil service retirement system, and other income maintenance programs. A 1-percent increase in the inflation rate, for example, adds about $1 billion in benefit payments to social security and more than $100 million to civil service annuities. [The Social Security Administration estimates cash benefit payments in 1978 at about $93 billion. A 1-percent rise in prices increases benefits by almost $1 billion—$93 billion multiplied by 1 percent equals $930 million. Similarly, the civil service retirement program pays between $9 and $10 billion—in round numbers. A 1-percent increase in the inflationary rate boosts annuity payments approximately $100 million ($10 billion multiplied by 1 percent equals $100 million.)]

Social security's recent need for additional financing—especially over the short range—was attributed in large part to accelerated inflation. Rapidly rising prices caused substantially higher benefit payments than initially forecast. The Social Security Administration estimated in late 1973 (using intermediate assumptions),[8] that cost-of-living increases would amount to 3.1 percent in 1973, 3.1 percent in 1976, and 5.8 percent in 1978. But prices leaped forward at an accelerated pace, pushing the cost-of-living increases up to 8 percent in 1975, 6.4 percent in 1976, 5.9 percent in 1977, and 6.5 percent in 1978. The compound effect of these four adjustments amounted to 29.7 percent, compared with the original projection of 12.5 percent. Translated into dollars and cents, inflation increased social security's benefit payments by about $27.9 billion from July 1975 to December 1978.

---

[7] Public Law 95-216, approved Dec. 20, 1977.

[8] These estimates were provided to the House Ways and Means Committee during consideration of the two-step, 11-percent social security increase Public Law 95-233, approved Dec. 31, 1973.

IMPACT OF INFLATION UPON SOCIAL SECURITY

Date	1973 cost-of-living assumptions when the House of Representatives considered the 2-step, 11-percent social security increase (percent)	Actual cost-of-living increase (percent)	Additional benefit payments because of higher inflation for the calendar year (in billions of dollars)
July 1975	3.1	8.0	1.6
July 1976	3.1	6.4	4.7
July 1977	0	5.9	9.0
July 1978	5.8	6.5	[1] 12.6
Total			27.9

[1] Estimate.

Source: Social Security Administration.

Inflation has also materially affected the civil service retirement system. From fiscal year 1966 to fiscal year 1977, annuity payments jumped by 516 percent, from $1,322 to $8,143 million—in large part because of inflation, a major increase in the number of retirees, earlier retirement, and other factors.

FEDERAL CIVIL SERVICE RETIREES AND BENEFITS, SELECTED FISCAL YEARS, 1966–76 [1]

Year	Number	Payment (millions)
1966	560, 992	$1, 322
1968	604, 873	1, 665
1970	662, 223	2, 129
1973	843, 520	3, 762
1974	938, 654	4, 825
1975	989, 786	6, 052
1976	1, 038, 377	7, 098
1977	1, 096, 561	8, 143

[1] Testimony by Ewan Clague at hearing cited in footnote 2.

Between 1975 and 1978, the rate of civil service annuity cost-of-living increases averaged 8 percent per year. If the cost-of-living increases had been 6 percent on the average instead of 8 percent, the civil service retirement system would have saved $2.3 billion.

IV. COST-OF-LIVING INCREASES FOR OLDER AMERICANS

Rising prices played havoc with the elderly's budgets throughout 1978. However, cost-of-living mechanisms in Federal income maintenance programs provided some measure of relief.

Nearly 34.5 million social security beneficiaries received a 6.5 percent cost-of-living adjustment on July 3. The increase was based upon the rise in prices from the first quarter—January, February, and March—in 1977 to the first quarter in 1978.

On an individual basis, the cost-of-living adjustment increased average monthly benefits from $407 to $432 for a retired couple, from $239 to $254 for a retired worker, and from $225 to $240 for an aged widow. The minimum monthly benefits for a worker 65 years or older rose from $114.30 to $121.80. And, the maximum benefit for a worker retiring in 1978 at age 65 increased from $459.80 to $489.70.

MONTHLY SOCIAL SECURITY BENEFITS: IMPACT OF 6.5-PERCENT COST-OF-LIVING INCREASE

	Prior law rate	6.5-percent cost-of-living increase
Maximum benefit for worker retiring in 1978 at age 65	$459.80	$489.70
Minimum benefit for worker retiring at age 65	114.30	121.80
Average benefit, retired worker alone	239.00	254.00
Average benefits, retired couple, both receiving benefits	407.00	432.00
Average benefit, aged widow	225.00	239.00
Average benefit, mother and two children	562.00	598.00
Average benefit, disabled worker with wife and children	532.00	567.00
Average benefit, all disabled workers	268.00	285.00

Other beneficiaries were also helped by cost-of-living adjustments. Nearly 4.3 million aged, blind, and disabled persons received a 6.5 percent cost-of-living adjustment in their supplemental security income payments. Qualifying individuals are now assured a minimum monthly income of at least $189.40, compared with $177.80 under prior law. The minimum monthly income floor for aged couples rose from $266.70 to $284.40.

MONTHLY SUPPLEMENTARY SECURITY INCOME PAYMENT STANDARD (FEDERAL)

	Prior law rate	6.5-percent cost-of-living increase
Qualifying individual	$177.80	$189.40
Qualifying couple	266.70	284.10

More than 1 million railroad retirees and their families were eligible for a cost-of-living adjustment. Retired employees and their spouses were eligible for a 6.5-percent increase on the tier I portion of their railroad retirement annuities. This amount, however, was offset by any social security cost-of-living increase that the annuitant received. Retired railroad employees and their spouses also received a 2.1-percent increase in the tier II portion of their annuities. This represented the second of four annual tier II increases authorized under the 1974 Railroad Retirement Act Amendments.[9] Widows and other survivors received a 6.5-percent cost-of-living increase for both tiers of their annuities. Their tier I annuity increase, though, was reduced by any social security cost-of-living adjustment.

In addition, 1.5 million civil service retirees and survivors received two cost-of-living increases: 2.4 percent in April, and 4.9 percent in October. The April adjustment was based upon the rise in prices for the 6-month period from June 1977 to December 1977, and the October increase reflected the inflation rate from December 1977 to June 1978.

V. MEANING OF THE NEW POVERTY STATISTICS

Our Nation has made considerable progress in reducing poverty among older Americans during the past decade. In 1967, almost 5.4 million persons 65 or older were considered poor under the Government's definition of poverty. Ten years later this number declined to 3.2 million.[10]

---

[9] Public Law 93-445, approved Oct. 16, 1974.

PERSONS 65 YR OR OLDER BELOW THE POVERTY LEVEL: 1967 TO 1977

[Numbers in thousands]

Year	Number below the poverty level	Poverty rate (percent)
1977	3,177	14.1
1976	3,313	15.0
1975	3,317	15.3
1974[1]	3,085	14.6
1974	3,308	15.7
1973	3,354	16.3
1972	3,738	18.6
1971	4,273	21.6
1970	4,709	24.5
1969	4,787	25.3
1968	4,632	25.0
1967	5,388	29.5

[1] Based on revised methodology. In 1974, the Bureau of the Census revised the methodology to reduce the nonsampling error (i.e., certain response, enumeration, and processing errors). The differences between the original and revised 1974 estimates are because of changes in the magnitude of the nonsampling error associated with the statistics. The differences result from one or more of the following four factors: (1) Changes in procedures which impute missing responses to the income and work experience questions on the March Current Population Survey (CPS) questionnaire, (2) changes in the March CPS income and work experience questions, (3) changes in the number of detail of tabulated income intervals, and (4) the correction of several small errors found in the processing system. For more information, see "Characteristics of the Population Below the Poverty Level: 1975," series P-60, No. 60, issued June 1977, pp. 6-12. Poverty data for 1975, 1976, and 1977 reflect this revised methodology.

Source: Bureau of the Census, "Money Income and Poverty Status of Families and Persons in the United States: 1977" (advance report), series P-60, No. 116, issued July 1978, p. 21.

During this same period, the total number of older Americans increased by 4.2 million. The net impact is that 19.3 million persons 65 or older do not live in poverty today, or 6.4 million more than in 1967 (12.9 million).

PERSONS 65 YR OR OLDER BELOW AND ABOVE THE POVERTY LEVEL: 1967 AND 1977

[Numbers in thousands]

Year	Total[1]	Number below the poverty level	Number above the poverty level
1977	22,468	3,177	19,291
1967	18,245	5,388	12,857
Difference	+4,223	−2,211	+6,434

[1] The universe for determining poverty does not include the institutionalized aged.

Source: Bureau of the Census.

---

[10] See following table:

WEIGHTED AVERAGE THRESHOLDS—POVERTY CUTOFFS IN 1977, BY SIZE OF FAMILY AND SEX OF HEAD, BY FARM-NONFARM RESIDENCE

Size of family unit	Total	Nonfarm			Farm		
		Total	Male head	Female Head	Total	Male head	Female head
1 person (unrelated individual)	$3,067	$3,705	$3,214	$2,969	$2,588	$2,672	$2,498
14 to 64 yr	3,147	3,152	3,267	3,023	2,709	2,776	2,569
65 yr and over	2,895	2,906	2,936	2,898	2,475	2,495	2,563
2 persons	3,928	2,951	3,961	3,907	3,318	3,325	3,176
Head 14 to 64 yr	4,054	4,072	4,095	3,981	3,406	3,474	3,278
Head 65 yr and over	3,637	3,666	3,670	3,646	3,128	3,131	3,079

Source: Bureau of the Census, "Money Income and Poverty Status of Families and Persons in the United States: 1977" (advance report), series P-60, No. 116, issued July 1978, p. 20.

The rate of poverty among the elderly has also been slashed substantially, from 29.5 percent in 1967 to 14.1 percent in 1977. Social Security increases, improvements in other income maintenance programs, and the establishment of supplemental security income have all helped to improve the economic well-being of older Americans.

To a very large degree, the reduction in poverty was achieved during the period 1967–74—when the elderly received five across-the-board social security increases aggregating 90.5 percent.[11] Since 1974, the number of older Americans living in poverty has essentially stabilized.

The 1974–75 recession contributed to a 200,000 increase in poverty in 1975. A 1978 advance report from the Census Bureau[12] provides new information about improved economic conditions for many older Americans, although not all groups of elderly—especially members of minority groups. From 1976 to 1977, the number of low-income persons 65 or older declined by 136,000—from 3,313,000 to 3,177,000.

However, poverty increased among elderly members of minority groups by 71,000—from 680,000 to 751,000. In addition, the proportion of low-income minority rose from 32.7 percent in 1976 to 34.9 percent in 1977.

The minority aged made rapid economic gains between 1967 and 1973. In 1967, more than one out of every two (51 percent) persons 65 or older who were black or members of other races lived in poverty. By 1973, about 1 out of 3 (35.5 percent) aged members of minority groups were poor. From 1973 to 1977, there has been almost no decline in the poverty rate among the minority aged. On the other hand the poverty rate for elderly whites has declined from 14.4 percent to 11.9 percent in 1977.

PERSONS 65 YR OR OLDER BELOW THE POVERTY LEVEL BY RACE: 1967–77

[Numbers in thousands]

Year	Number below the poverty level	Poverty rate (percent)
White:		
1977	2,426	11.9
1976	2,633	13.2
1975	2,634	13.4
1974	2,460	12.8
1974	2,642	13.8
1973	2,698	14.4
1972	[illegible],072	16.8
1971	[illegible]	19.9
1970	3,984	22.5
1969	4,052	23.3
1968	3,939	23.1
1967	4,646	27.7
Black and other races:		
1977	751	34.9
1976	680	32.7
1975	683	34.0
1974	625	32.[illegible]
1974	666	34.[illegible]
1973	656	35.5

---

[11] Social security beneficiaries received across-the-board increases of 13 percent in 1968 (effective February 1968), 15 percent in 1970 (effective January 1970), 10 percent in 1971 (effective January 1971), 20 percent in 1972 (effective September 1972), and 11 percent in 1974 (7 percent for March, April, and May 1974), with the full 11 percent payable for months after May 1974). The increases total 69 percent. However, the aggregate benefit boost is 90.5 percent because of the compound effect of adding one increase on top of another.

[12] "Money Income and Poverty Status of Families and Persons in the United States: 1977" (advance report), series P–60, No. 116, issued July 1978.

PERSONS 65 YR OLD OR OLDER BELOW THE POVERTY LEVEL BY RACE: 1967–77—Continued

[Numbers in thousands]

Year	Number below the poverty level	Poverty rate (percent)
White:		
1972	666	37.5
1971	668	38.4
1970	725	46.2
1969	735	48.1
1968	693	46.6
1967	742	51.0
Black:		
1977	701	36.3
1976	644	34.8
1975	652	36.3
1974	591	34.3
1974	626	36.4
1973	620	37.1
1972	640	39.9
1971	623	39.3
1970	683	48.0
1969	689	50.2
1968	655	47.7
1967	715	53.3

Source: Bureau of the Census, "Money Income and Poverty Status of Families and Persons in the United States: 1977" (advance report), series P-60, No. 116, issued July 1978, p. 21.

VI. AN END TO POVERTY: HOW NEAR?

Abolition of poverty among older Americans has been a major goal of the Committee on Aging. Considerable progress was made in implementing that goal during the late 1960's and early 1970's (see page 36 for more details). However, much more remains to be done, since 3.2 million older Americans—or about one out of every seven persons 65 or older—lives in poverty.

The committee gave considerable attention to this issue during hearings on "Retirement, Work, and Lifelong Learning."[13] Senator Church, for example, asked HEW Secretary Joseph Califano to estimate the net cost to abolish poverty among older Americans. Secretary Califano provided the following information for the hearing record:[14]

> Under the SSI program, States spend approximately $1.5 billion each fiscal year in supplementation costs. Raising the Federal SSI guarantee to the poverty level would reduce State expenditures by about 70 percent.
>
> The 1978 nonfarm poverty line for a head of household age 65 or older is $3,080. Estimates of the minimum cost—the cost for people already receiving SSI—and the maximum cost—the cost for everyone eligible to receive SSI payments—if the Federal SSI guarantee for an individual were raised to the $3,080 amount for the period July 1, 1977, through June 30, 1978, are shown below:

Minimum estimate:	
Program costs (billion)	$8.3
Beneficiaries (million)	4.2
Maximum estimate:	
Program costs (billion)	12.2
Beneficiaries (million)	9.3

---

[13] Hearings were held in Washington, D.C., on July 17, 18, and 19 and September 8, 1978.
[14] Response included in July 17, 1978, hearing cited in footnote 2.

Senator Church subsequently asked Secretary Califano in a follow-up letter (July 31, 1978) what would be the most effective approach to abolish poverty for the elderly.[15] Secretary Califano replied:

> There are two conflicting needs that we face in any effort to abolish poverty—that of keeping future costs under control and of increasing benefits for people whose income is inadequate.
>
> The earnings related social security programs should remain the Nation's primary means of providing economic security for older Americans. The system lends itself well to supplementation by private pensions, savings, and other individual and group efforts to provide economic security. We recognize that social insurance cannot provide an adequate income for those who have had little or no earnings during their working years. Thus, an effective means tested program to provide basic income for people with low income is a necessary third ingredient to meet any need for cash income that social security and private resources cannot provide.
>
> The Advisory Council on Social Security that was appointed in February 1978 is currently studying all aspects of the social security program. The Council will be focusing on selected issues dealing with the role of social security in the future, including the issues raised by your questions. In addition, as you know, the Social Security Amendments of 1977 established a National Commission on Social Security, which will be jointly appointed by the President and the Congress, to make a broad-scale comprehensive study of the social security program. Along with the financial status of the social security program, coverage, and benefit adequacy, this Commission may study possible alternatives to the current program, including integration of the current program with private retirement systems.
>
> Further study of this sort will be carried out by the Presidential Commission on Pension Policy. Established under an Executive order, the Commission will examine pension systems around the country in an effort to develop national policies for retirement, survivor, and disability programs that can serve as a guide for public and private programs. The Commission on Pension Policy will coordinate its work of the Advisory Council and the National Commission.[16]

SIGNIFICANCE OF VETERANS' LEGISLATION

Enactment of the Veterans' and Survivors' Pension Improvement Act[17] represented one of the most significant legislative developments in 1978 affecting the economic well-being of the elderly. Public Law 95-588 assures all veteran pensioners an income above the poverty level. The new legislation increases the maximum annual rates effective January 1, 1979 from $2,364 to $3,550 for single veterans and from $2,544 to $4,651 for a veteran with a dependent. These rates are $800 higher for a veteran of World War I. Public Law 95–588 is expected to remove 150,000 to 200,000 veterans from the poverty rolls.

---

[15] Senator Church wrote Secretary Califano on July 31, 1978, and posed this question: "If our Nation decides to abolish poverty for older Americans, what would be the most effective way to approach this goal? For example, should the emphasis be on supplemental security income, social security, a combination of these two programs, or some other approach?"

[16] Response included in July 17, 1978, hearing cited in footnote 2.

[17] Public Law 95-588, approved Nov 4, 1978.

Another major purpose of the act is to assure that VA pensions will never be reduced because of social security cost-of-living increases. Public Law 95–588 automatically indexes pension rates to the Consumer Price Index on the same basis as social security. Thus, when social security benefits are increased, veterans will receive the full cost-of-living adjustment in their pensions as well.[18]

---

[18] Example: The maximum annual pension rate for a single veteran is $3,550. Assuming the veteran is receiving $2,500 in social security benefits (or any other source of annuity payments) and $1,050 in VA pension benefits at the time social security benefits are increased, and the social security increase was 6 percent, the maximum support level for pension purposes would be calculated as follows:

Annual social security benefits	$2, 500
Cost-of-living social security increase	×.06
Additional social security benefits	$150
Annual VA pension benefits	$1, 050
Cost-of-living pension increase	×.06
Additional pension benefits	$63

This would provide an additional $213 annual benefit. The annual maximum income support level would, as a result of the indexing, be raised by 6 percent from $3,550 to $3,763. Thus, the individual receives a full pension increase of 6 percent as well as a full 6 percent increase in social security.

CHAPTER III

HEALTH: HIGH COSTS AND NEW APPROACHES

I. THE INDIVIDUAL BURDEN

The personal share of health care expenditures for the elderly, that which is paid for by the elderly themselves, continues to increase.[1]

The out-of-pocket share of total national health care expenditures for the elderly is the highest it has ever been. During 1977, each older American spent $613 for medical services—35 percent of their total health care bill.[2]

Total per capita personal health care outlays for the elderly during 1977 were $1,745. This is a 15 percent increase over 1976, and an increase of 31 percent in a period of 3 years. (Per capita personal health care expenditures for the elderly were $1,336 in 1975; $1,521 in 1976.)

Most of the public share for national health care expenditures of the elderly comes from medicare and medicaid.

During 1977, medicare paid for about 44 percent of the total health expenditures of the elderly. When medicare's cost-sharing amounts, paid for by beneficiaries themselves, are deducted, medicare actually paid for only 41 percent of the elderly's total health care expenditures nationwide.

State medicaid programs paid for an additional 16.7 percent of the total health care expenditures of the elderly. This is a minimal increase over 1976 payments, when medicaid accounted for 16 percent of the total health care expenditures of the elderly.

The annual rise in out-of-pocket payments for health care services is perhaps most directly evident when medicare's coinsurance charges increase.

The amounts each medicare beneficiary must pay out-of-pocket for medicare's hospital insurance will increase by 11 percent on January 1, 1979. The initial deductible for hospital stays under medicare part A will increase to $160 per benefit period, up from $144 during 1978. When medicare first took effect, in 1966, the in-patient hospital deductible was $40.

The coinsurance charges for long-term hospital and skilled nursing days will also increase 11 percent on Jauuary 1, 1979.[3]

---

[1] Statistics from "Age Differences in Health Care Spending, Fiscal Year 1977," Social Security Bulletin, vol. 42, No. 1, January 1979.

[2] Reference cited in footnote 1. The comparable figure published for the year 1976 was $404, which did not include private health insurance premiums or medicare's coinsurance charges paid for by the elderly themselves. The 1977 data includes these charges, which is a more accurate reflection of the out-of-pocket share. (If the coinsurance charges and private health insurance premiums are not included, the 1977 figure is $463, about a 15 percent increase.)

[3] Daily coinsurance charges for the 61st through the 90th day of hospitalization will rise from $36 to $40. From the 91st day through the 150th day, the charge will rise from $72 to $80 per day. The daily charge for skilled nursing days, from the 21st through 100th day, will rise from $18 to $20.

II. ELUSIVE GOAL: HOSPITAL COST CONTAINMENT

Hospital costs continue to rise at least 1½ times the rate of inflation.[4] Congressional efforts to pass legislation which would have placed mandatory cost controls on hospitals failed during 1978. Voluntary efforts initiated by the hospital industry reportedly decreased the rate slightly early last year. However, HEW predicts that if hospital controls are not adopted, then the medicare deductible will climb from its present $160 to $276 by 1983.[5]

A. Costs Continue to Rise

Hospital costs alone account for 40 percent of all health care expenditures.[6] They are the most inflationary element in the health care sector, increasing 15.6 percent in 1977 alone. HEW stated that early estimates for 1978 were already at 13.6 percent.[7] Further, the cost of hospital care was averaging $140 per day—an increase of $22. The average stay of about 7 days costs $1,363.[8]

B. Voluntary Effort

The American Hospital Association, the American Medical Association, and the Federation of American Hospitals announced a voluntary effort to reduce the spiraling inflation rate in hospital costs by 2 percent a year for the next 2 years.

Projections by the Congressional Budget Office estimate that during early 1978, inflation in hospital costs had decreased from 15.6 percent to 13.6 percent.[9]

C. Legislation Fails

House and Senate Health Committees took differing routes to curb inflation in hospital costs.

—In February, the House Ways and Means Health Subcommittee, on a 7-to-6 vote, approved a bill calling for mandatory controls if, after 2 years, voluntary efforts by the hospital industry fail to slow the cost increases.

—During 7 weeks of debate in June and July, the House Interstate and Foreign Commerce Committee considered the bill. The committee defeated Federal controls by a vote of 22 to 21. The committee then approved a substitute bill asking hospitals to cut revenue increases by 2 percent a year. It also proposed a Presidential commission to oversee the effort. In addition, States that initiate their own cost commissions would be given financial assistance.

—Senator Herman Talmadge attached his Medicare and Medicaid

---

[4] "Hospital Cost Containment," a summary of legislation pending before the Senate of the United States, prepared by the Department of Health, Education, and Welfare, July 1978, p. 2. See also Congressional Budget Office report, "The Voluntary Effort to Control Hospital Costs: A Preliminary Assessment," March 1979.

[5] Washington Post, Dec. 29, 1978.

[6] See report cited in footnote 4, p. 43.

[7] Draft paper from the Congressional Budget Office, March 1979. CBO estimates that because hospital rates increased 2 percent in the last part of 1978, inflation will be higher than last year's rate.

[8] See report cited in footnote 4, p. 2.

[9] See report cited in footnote 7, p. 11.

Reimbursement Reform Act [10] to a House-passed tariff measure and sent it to the Senate floor in August. The Talmadge bill did not reach a vote in the final days of the session.

—Senator Edward Kennedy introduced a bill similar to the administration's 1977 Hospital Cost Containment Act.[11] The Senate rejected the mandatory program in favor of a voluntary one introduced by Senator Gaylord Nelson.[12] The Nelson proposal, as passed, was similar to that passed by the House Ways and Means Subcommittee.

—The House adjourned before the measure could be brought up for a vote.

Late in December, the Carter administration asked the Nation's hospitals to hold their 1979 spending to a 9.7-percent increase.[13] The voluntary goal would be a reduction of 25 percent in the present inflation rate and would be part of the President's anti-inflation guidelines.[14]

D. State Initiatives

Most of the hospital cost containment proposals would exempt States that have health care rate setting commissions. Currently, Connecticut, New York, California, and Massachusetts have established hospital costs control commissions and rate-setting boards. An example of one such State commission is in Maryland where the Maryland Health Services Cost Review Commission reports that hospitals had increases of only 9 percent as compared to a nationwide average of 14 percent.[15]

The Indiana Hospital Association and Blue Cross established their own cost-control program under the auspices of a Department of Health, Education, and Welfare grant. The program estimates to have saved health care consumers 10 percent since 1973.[16]

In North Dakota, citizens defeated an initiative on the November ballot that would have regulated all health-care costs.[17]

The Carter administration has set hospital cost containment as a priority in 1979. With voluntary and State efforts being initiated, debate on methods for decreasing the rate of inflation in the hospital sector will continue to be in the national political arena.

III. INCREASING ATTENTION TO "ALTERNATIVES"

HEW Secretary Joseph Califano, testifying before members of this committee, posed what he called a critical question facing our society in the coming years:[18]

---

[10] The Medicare and Medicaid Reimbursement Reform Act would establish a new method of reimbursement for routine hospital operating costs under medicaid and medicare, providing incentive reimbursements for hospitals whose routine costs are below the average and penalties for those with costs exceeding 120 percent of the average. Also see "Developments in Aging: 1977," part 1, pp. 59–60.

[11] See Congressional Record, Oct. 12, 1978, p. S18353. The administration's bill had two major elements to contain costs. They would establish an overall ceiling on total inpatient revenues, limit allowable increases to 9 percent by fiscal year 1981; and second, would set limits on capital expenditures for hospital construction. Also see "Developments in Aging: 1977," part 1, pp. 59–60.

[12] See Congressional Record, Oct. 12, 1978, p. S18353.

[13] Washington Post, Dec. 29, 1978.

[14] The hospital industry announced, as reported, in the Washington Post, Jan. 6, 1979, that they would reject Secretary Califano's 9.7-percent ceiling on increases. The American Hospital Association predicted there would be "extensive rationing of care" if hospitals were forced to keep their expenses from climbing above the 9.7 percent Califano requested.

[15] Washington Star, Dec. 28, 1978, p. Mc1.

[16] Journal of the American Hospital Association, September 1978.

[17] Wall Street Journal, Oct. 31, 1978.

> How shall we deliver the services older citizens need—health care and social services—more compassionately and efficiently?

He cited a 40-percent increase in costs in medicare and medicaid between fiscal years 1976 and 1978, with little increase in the covered population and benefits. There will be a tenfold increase in cost of those programs by the year 2025, he said:

> We must be at least equally concerned about the shortcomings of this expensive system. For all the money we spend, major needs remain unmet. As the elderly population increases—especially those 75 and over, who are especially likely to have serious health problems—these needs will increase . . . We must build a rational, comprehensive, efficient, and humane system for delivering health and social services.

Such a system should include:

—Adequate, supervised residential facilities for those who lack families but want to live in their communities.

—Special services for those who live at home but need help from outside: transportation or shopping help, for example, and help with meals and personal care.

—A range of alternatives between the hospital and the nursing home, including a system of home health care.

—Innovative and compassionate ways of caring for the terminally ill outside the traditional hospital or nursing home.

Secretary Califano also directly acknowledged that there is no such system now:

> We have, instead, a confusing and expensive patchwork of financing systems that spawn an even more inadequate delivery system.

Calling home health care a worthwhile alternative to nursing home care for many people, he pointed to what he termed an acute-care bias in medicare and the institutional bias in medicaid, and said we have not yet developed an adequate system of community and home health care.

How can we end the fragmentation of services for the elderly and insure that the needs of the elderly are properly identified? His answer: "We don't know yet."

Secretary Califano offered three alternatives:

(1) Revising medicare and medicaid to make home health benefits the same in both programs, and relaxing the current restrictions on skilled nursing benefits only, or creating a new financing structure to expand the range of health and social services available to the elderly.[19]

---

[18] Secretary of Health, Education, and Welfare Joseph A. Califano, Jr., testimony before the Senate Special Committee on Aging, July 17, 1978.

[19] Testimony cited in footnote 18. Secretary Califano also suggested that this option poses problems of aggravating inflation in health costs, and that questions still remained about the potential for overuse of chronic care services in the same way acute care services are now being overused. He also speculated that such an approach ought not to reduce incentives for families to provide their own care.

(2) Creating special health maintenance organizations for the elderly, providing a broader range of services than conventional HMO's.[20]

(3) Creating a separate financing and delivery system for long-term care, which would integrate current long-term care expenditures from medicare and medicaid (including nursing home and home health care) with a broad new range of support services.

PRESSURES INCREASING

Looking to the future, another administration representative warned Congress and the Nation to brace for significantly increased demands for the homebound and other elderly victims of chronic illness.

Robert Benedict, named as U.S. Commissioner on Aging in 1978, made these predictions:[21]

> As the population ages, more older people will fall into the category that the Federal Council on Aging has called the frail elderly, those elderly people whose ability to function in the ordinary business of daily living has become limited because of the increased infirmities of later life. . . . We can expect that the continuing increase of the very old population will mean a greater incidence of disability and isolation over the years. The population 65+ will increase by about 500,000 persons each year over the next half century. It is estimated that between 80,000 and 100,000 of those persons will need assistance to remain in the community. These facts portend increasing pressures on the family, special living arrangements, community service programs, and nursing homes and other institutions.

There is new urgency in the statistics of the "old old." Dr. Harold Sheppard told the committee that, in 1960, there were 34 persons age 80 and over for every 100 persons age 60 to 64, the "young old." By 1970, the ratio had increased to 46. By 1980, it will probably be 52. By the end of the next decade—by 1990—we can expect to find 63 very old persons for every 100 age 60 to 64. By the end of the century, the proportion will rise to 79.[22]

STATUS OF THE "FRAIL ELDERLY"

The Federal Council on Aging established a task force on the frail elderly in 1975. A seminar was held with national experts to assist the Council develop a targeted focus on the "frail elderly."[23] The Council held several meetings over the next 3 years to develop a public policy report on the frail elderly.

---

[20] Secretary Califano noted that the administration had already proposed legislation to permit broadened medicaid and medicare funds to be used to pay for more participation by the elderly in conventional HMO's.

[21] Robert C. Benedict, Commissioner on Aging, Department of Health, Education, and Welfare, in testimony before the Subcommittee on Aging, Senate Committee on Human Resources, U.S. Senate, Apr. 21, 1978.

[22] Dr. Harold L. Sheppard, Center on Work and Aging, American Institutes for Research, in testimony before the Senate Committee on Aging, July 17, 1978. See chapter I of this report for a more detailed discussion of demographic trends.

[23] Defined as the oldest among the elderly, usually age 75 or over, who, because of the accumulation of continuing problems, often require one or several supportive services in order to cope with daily life.

During 1978, Federal Council staff prepared a draft study discussing the status of this group of the "oldest of the old" and made preliminary recommendations:[24]

—The population 75 years of age and older has experienced a 10-fold increase since 1900, and the age group 85 years of age and older has grown by about 17 times. Concurrently, about 40 percent of the elderly population is 75 and over, and this proportion is expected to increase to 45 percent by the year 2000.

—There is sufficient evidence regarding a continuing lessening of physiological and social well-being with increasing age to support, (1) a public policy of social intervention for the frail elderly to provide services not available in the marketplace and (2) provision of social services based on automatic entitlement to assure access to services by all those who become frail.

The staff study recommends:

—Systematizing aid to persons who need direct personal assistance from society on a continuing basis by establishing a freestanding case assessment and case management service as an entitlement of the frail elderly upon reaching a certain age, on a national and voluntary basis. Frail persons below the age could be qualified by some functional eligibility determination.

—Developing a plan of care, by skilled practitioners, in conjunction with the older person and his or her family and/or friends. A priority in the assessment and plan process would be identification of a "significant other" person or persons to help the older person cope with daily needs.

Additional recommendations to further the overall goals of meeting the needs of the frail elderly include:

—Elimination of the current reduction in the supplemental security income benefit of elderly recipients residing in the household of another. This would encourage families and friends to maintain older relatives or friends in their homes as long as possible.

—Development of a long-term care social support system, as a matter of national priority, to complement the national long-term care health system.

STATES SEE GROWING NEED

Preliminary results from a committee survey of State development of alternative programs of community long-term care indicates a growing sense of urgency to find ways to meet the needs of the growing older population with nontraditional ways of providing services.

Many of the States report encountering significant problems.

Alaska.—"Long-term care clients are confronted with an array of services offered by an array of providers. . . . The result is all too frequently inappropriate institutionalization or preventable patient debilitation leading to institutionalization. . . . The overriding obstacle to the creation and continuing operation of institutional alternatives (outreach, counseling, long-term care, respite, rehabilitation, training, screening, and placement) is a reliable and consistent funding source. Continuum of service delivery, both into the home and into the alternative residential setting to avoid premature nursing home admission and retention, is desperately needed." [25]

---

[24] "Public Policy and the Frail Elderly," a staff study. Federal Council on the Aging. Washington, D.C., 1978; in draft form, not yet released.

Florida.—"It is important to note that when we speak of a continuum of care, the range of services provided must address the physical, social, emotional, functional, and environmental aspects of an individual's needs. Therefore, the integration of both health and social services into a single service system is perhaps the most problematic area in developing this program. We have, in our efforts to develop this comprehensive system, encountered innumerable barriers created by the categorical arrangement of funding sources." [26]

New Hampshire.—"Despite our efforts as an agency to develop comprehensive services at the local level and to coordinate with other funders . . . we are hampered by the continuing lack of direction at the Federal level. If a truly coordinated service system ever becomes a reality, this will occur when Congress takes the initiative in requiring rather than requesting that this coordination takes place." [27]

Wyoming.—"The numbers of qualified and adequately trained personnel in the rural areas are very limited. Those who are available in the area are grossly overworked. We do not have a demonstrated cost-effective service delivery model in a rural State. Research and demonstration projects are needed in this area." [28]

Nebraska.—"Nebraska is keenly interested in the continuum of care concept and the provision of appropriate services, both institutional and community-based. A number of problems have been encountered in the development of coordinated service delivery, however. Among those which are appropriate for Federal action are review, and possible modification, of eligibility criteria and regulations, standardization of reporting requirements, and legal vesting of authority in one lead agency." [29]

A. THE ADMINISTRATION: BEHIND SCHEDULE

The urgency echoed in Secretary Califano's testimony before the committee in July followed by almost 9 months his designation of the Health Care Financing Administration as the "focal point" for development of long-term care policies within the Department of Health, Education, and Welfare.[30] In October of that year, HCFA Administrator Robert Derzon transmitted to the committee the administration's timetable for long-term care policy development.

By March 1978, the administration would submit to Congress its proposals for national health insurance. The proposal, the timetable said, would include a decision on how long-term care services were to be treated within national health insurance.

---

[25] Letter to Senator Frank Church from Helen D. Beirne, commissioner, State of Alaska Department of Health and Social Services, Dec. 13, 1978.

[26] Letter to Senators Church, Chiles, and Domenici from E. Bentley Lipscomb, program staff director, Aging and Adult Services, State of Florida Department of Health and Rehabilitative Services, Dec. 7, 1978.

[27] Letter to Senators Church, Chiles, and Domenici from Claira P. Monier, director, New Hampshire State Council on Aging, Dec. 14, 1978.

[28] Letter to Senators Church, Chiles, and Domenici from James Hammer and Nancy Krois, Office on Aging, Department of Health and Social Services, State of Wyoming, Dec. 12, 1978.

[29] Letter to Senators Church, Chiles, and Domenici from David M. Howard, executive director, Nebraska Commission on Aging, Dec. 13, 1978.

[30] See "Developments in Aging: 1977," part 1, U.S. Senate Special Committee on Aging, p. 65, for discussion of the HEW commitment and other activities during the year. Since that time, Robert Derzon has left HCFA and a new Administrator has been appointed.

In July 1978, the administration announced a set of "principles" to serve as a guide in preparation of national health insurance legislation. They did not address the health problems of older Americans and specifically excluded any discussion of long-term care issues.[31]

By August 1978, the administration was to have transmitted to Congress a report on the results of major research conducted during recent years to assess the feasibility of including such benefits as homemaker and day care services in medicare and medicaid.

No report has yet been transmitted to Congress.[32]

By December 1978, the administration was to have formulated its plans for development and testing of major alternative service delivery and financing methods. Goals were to test models for coordinating services and providing a community-based continuum of care for the chronically ill and disabled to eliminate problems of fragmentation and institutional biases in long-term care.

No plans have yet been transmitted to Congress, and a proposal made by Secretary Califano for $100 million for special demonstration projects in long-term care during fiscal year 1980 was rejected by the Office of Management and Budget.[33]

By December 1978, the administration would transmit to Congress a full report on home health services with recommendations for service availability and provision, program administration, and reimbursement and costs of home health programs under medicare, medicaid, and title XX. The report would also include recommendations for coordination of home health resources among the three programs, service utilization control, and prevention of fraud and abuse.

The report has not yet been made public.[34]

SETBACKS IN THE FISCAL YEAR 1980 BUDGET PROPOSAL

In order to implement the Department's long-range goals of testing and demonstrating major new delivery systems for alternative forms of long-term care, an early HEW budget memorandum for fiscal year 1980 included a special request for $100 million for demonstrations of effective methods of organizing and delivering long-term care services.[35] The major portion was to be for the development of specialized long-term care agencies which would perform a central role of assessing a patient's service needs, make the appropriate services available to the patient, and coordinate and integrate existing mental health, health, and social services to meet individual needs.

This initiative, however, did not appear in the final version of the administration's budget request to Congress for fiscal year 1980.[36]

The highly successful home health demonstration program was also severely cut in the fiscal year 1980 budget request.[37] The budget proposed a cut from $6 million (the fiscal year 1979 funding level) to $804,000, to phase the program out during the year.

---

[31] See p. 60 of this report for a discussion of national health insurance proposals.

[32] See next page for a discussion of initial findings from the section 222 demonstrations. The full report, which is to include recommendations, has not yet been released.

[33] See next page for further details on the original HEW proposal and p. 52, following, for discussion of similar legislative authority.

[34] HEW's final report, with recommendations, was expected to be made available to Congress by April 1979.

[35] Memorandum from HEW Secretary Joseph Califano to HEW staff, Oct. 2, 1978.

[36] "The Budget of the U.S. Government, fiscal year 1980."

[37] Document cited in footnote 36. See p. 52, following, for program history and congressional action to reauthorize the program through fiscal year 1981.

WHAT DO WE KNOW? THE SECTION 222 DEMONSTRATIONS

The 1972 amendments to the Social Security Act mandated an evaluation of the feasibility of including geriatric day care and homemaker services as a benefit in medicare and medicaid programs.[38]

Six demonstration projects were established, helped by special waivers for payment of homemaker and day care services for a period of 1 year. Most of the participants in the demonstration programs were over the age of 75, female, and widowed.[39]

In an early report of the findings of the experiments, HEW researchers found that the new services offered substantial benefits to participants:[40]

—Participants, particularly those who received homemaker services, experienced lower death rates.

—Increased physical dependency was postponed or entirely avoided through the use of day care services.

—Contentment was sustained or increased, particularly for patients who had access to both homemaker and day care services.

—Day care services increased mental functioning and social activity levels.

—Day care services substantially reduced the likelihood of a patient entering a skilled nursing facility or a hospital. Day care services also reduced average hospital days used.

—The number of skilled home health visits needed by participants using day care services or day care and homemaker services together was significantly reduced.

—The cost to medicare for hospital days, skilled nursing day, and home health visits was reduced. Costs for the new services of day care and homemaker, however, offset these reductions.

WHERE DO WE STAND? THE HOME HEALTH DEMONSTRATIONS

A special demonstration program for the development and expansion of home health agencies, first authorized in 1975, has completed 3 years of operation.[41]

The program's goal was to encourage the development of home health services in underserved areas. Grants were made to finance the initial costs of establishing and operating new home health agencies until they could become self-sufficient, and to enable existing home health agencies, primarily those equipped to provide only a limited service, to expand their home service capabilities. A typical expansion made possible by a program grant was addition of homemaker services to skilled nursing and therapy services. The grants were targeted to areas of the country with limited, or no, home health services.[42]

---

[38] Section 222 of Public Law 92-603.

[39] Mean age for demonstration participants was 75.6 years; over 60 percent were women; about 50 percent were widowed. About one-third of the experimental population were classified as "severely dependent." The waivers allowed medicare and medicaid payments to be made for the services received. Day care and homemaker services are not covered by medicare and are only covered by medicaid in some States.

[40] "Effects and Costs of Day Care and Homemaker Services for the Chronically Ill: A Randomized Experiment," Department of Health, Education, and Welfare, National Center for Health Services Research, Jan. 19, 1979.

[41] The Home Health Extension Act was first authorized for fiscal year 1976 by an amendment, offered by Senator Frank Church, to the Health Revenue Sharing and Health Services Act, Public Law 94-63, enacted July 29, 1975. $3 million was authorized for demonstration and expansion grants. The program was extended through fiscal year 1977 as part of the Health Maintenance Organization Amendments of 1976, Public Law 94-460, with authorizations of $8 million for demonstration and expansion grants and $4 million for training of home health agency personnel. An additional $2 million for expansion grants and $1 million for training for the fiscal year 1976 transition quarter was also authorized by this measure. The program was extended for a third year, fiscal year 1978, as part of the Health Assistance Programs Extension Act of 1977. Authorizations for fiscal year 1978 were $8 million for expansion grants and $4 million for training. See p. 52, following, for further authorizations through fiscal year 1981.

Recognizing that there were few people adequately trained to provide home health services, the legislation made a separate authorization for grants to be used to train home health agency personnel.[43]

Grants totaling $11 million have been awarded to more than 200 agencies to develop home health services where none were previously available, and to provide an opportunity to expand the services of existing agencies. In addition, $1 million has been awarded to 21 programs to provide special training for about 3,000 home health aides.

Prior to the home health demonstrations program, 788 counties in the country were without the services of a medicare-certified home health agency; 135 of these counties now have a medicare-certified home health agency, serving almost 2 million people who did not have access to home health services before. Home health services have been expanded in an additional 446 counties. All of the 112 home health agencies awarded grants in 1976 and 1977 are now self-sustaining.

The Department of Health, Education, and Welfare is now evaluating the results of the startup and expansion grants authorized under the Home Health Extension Act, and a final report on program operations is expected at the end of March 1979.[44]

Three areas of program operation will be reported: (1) an evaluation of whether the specific legislative objectives of capacity-building and program expansion can be effectively met through such a grant program; (2) an evaluation of the program's ability to affect the distribution of trained home health personnel; and (3) an analysis of the costs of home health visits and the factors which contribute to utilization of home health services.

NEW ATTENTION TO HOSPICE SERVICES

The concept of "hospice" services, to help terminally ill patients remain as physically and emotionally comfortable as possible, has received extensive and favorable attention.[45]

Currently, hospice care in the United States is delivered in a number of settings: through specially designed programs of home care, through institutional hospices serving only dying patients, and through specially trained teams of hospice workers working within acute-care hospitals.

---

[42] Hearings conducted by the Committee on Aging had documented that the need for home care was particularly acute in rural areas where institutional facilities are limited or nonexistent. Many rural areas, however, had no home health agencies. Those which did often provided only the minimum limited service required to be eligible for medicare reimbursement—skilled nursing plus one other service, usually physical therapy.

[43] During the program's first 2 years of operation, grants were made for agency startup and service expansion only. No appropriations for training were made available until fiscal year 1978, the third year of operation.

[44] The evaluation is being conducted by the Center for Health Services Research, University of Colorado Medical Center, Denver, Colo., under a contract with the Department of Health, Education, and Welfare, Health Services Administration, Office of Planning, Evaluation, and Legislation, contract HSA 240-77-0148.

[45] See "Death With Dignity: An Inquiry Into Related Public Issues," hearings before the Senate Special Committee on Aging, U.S. Senate, Washington, D.C., Aug. 7, 8, and 9, 1972, for an early exploration of the hospice concept and other issues related to care of the terminally ill.

The major goals of hospice care focus on the needs of the dying patient and his family, including relief from pain through the use of drugs and psychological therapy in preparation for death.

The National Hospice Organization[46] held its first annual meeting in Washington, D.C., in October. Featuring keynote addresses by Secretary of Health, Education, and Welfare Joseph Califano and Senator Edward Kennedy, the conference also heard reports on the origins of the hospice care concept and discussed current issues in hospice care delivery.

Secretary Califano announced that a National Conference on the Care of Dying Patients would be convened next year to further refine these issues and explore approaches to private sector funding.

A special task force to examine current hospice activities within and outside the Federal Government has been formed by the Department of Health, Education, and Welfare. The task force will also make recommendations about the appropriate Federal role in hospice development.[47]

HEW's Health Care Financing Administration, which administers medicare and medicaid, has invited agencies providing hospice-oriented home care and in-hospital hospice care to submit proposals for special demonstration projects. State medicaid agencies were also invited to conduct special hospice demonstration projects.[48] The projects were solicited by HCFA to evaluate factors related to provision of hospice services in various settings in order to make long-range recommendations for medicare and medicaid coverage of specific hospice service components.

B. LEGISLATIVE EFFORTS

Home health demonstration continued.—In recognition of the success of the home health demonstration program, Congress reauthorized the program for an additional 3 years, through fiscal year 1981.[49] Fund authorizations were increased: $11 million is authorized for startup and expansion grants for fiscal year 1979, $12 million for fiscal year 1980, and $13 million for fiscal year 1981. Training grants are authorized at $1.5 million for fiscal year 1979, $2 million for fiscal year 1980, and $2.5 million for fiscal year 1981.

Congress had not passed a new appropriations bill by the end of the year, however, and the program entered 1979 under a continuing resolution at the fiscal year 1978 funding level of $5 million for startup and expansion grants, and $1 million for training.

Special HCFA demonstrations.—An amendment sponsored by Senator Lawton Chiles to provide an additional $5 million to the Health Care Financing Administration for special long-term care demonstrations was included in the fiscal year 1979 Labor-HEW appropriations bill.[50]

---

[46] NHO is the national hospice advocate group. Hospice, Inc., of New Haven, Conn., recently assigned its hospice service mark to NHO in order to allow for eventual control of the use of the word "hospice" by organizations. NHO estimates that there are approximately 200 groups in the country in various stages of developing hospice services. About 75 of these are actually delivering hospice care.

[47] A number of Members of Congress have also expressed interest in hospice, and an informal congressional working group has been participating in task force activities.

[48] 43 CFR, Oct. 27, 1978, pp. 50376–50378. The projects are to be conducted under the authority of section 402 of the Social Security Amendments of 1967, as amended by sec. 222(b) of Public Law 92–603, and sec. 1115 of the Social Security Act.

[49] Public Law 95–626, the Health Services and Centers Amendments of 1978. See p. 50 of this report for discussion of program performance during the past 3 years.

The additional funding is to be used for:[51]

—Development of community organizations to perform assessment of care needs, prescription of services, monitoring and reassessment of service needs, and quality assurance.

—Provision of a broad range of services, health and social, based on the needs of individuals rather than forcing people to fit into narrowly defined categories.

—Testing of various methods of financing long-term care services, such as fixed budgets, capitation, and sliding fee scales, to determine the effect on costs, utilization, and quality of care.

The Health Care Financing Administration is now reviewing a number of proposals for special projects. Announcements of grant awards will be made early during 1979.

Medicare home health benefits.—Even though both the House and the Senate passed bills which would have expanded medicare's home health benefits, final agreement was not reached.

A House-passed bill would have removed the 100-visit limitation for home health services under medicare parts A and B, eliminated the requirement for a prior 3 days of hospitalization under medicare part A, eliminated the $60 deductible for home health services under part B, and eliminated the present medicare requirement that proprietary home health agencies be licensed by a State before becoming eligible for medicare reimbursement.

In addition, the HEW Secretary would have been required to establish additional standards for home health agencies participating in medicare, and to establish regional intermediaries for home health agencies. The bill also required training programs for home health aides, and would have barred a physician who certifies eligibility for home health services from having a substantial financial relationship with the agency providing home health services.[52]

The Senate-passed bill would also have repealed the requirement for a prior stay of 3 days in a hospital to be eligible for home health services under medicare part A and removed all limitations on the number of home health visits allowed under medicare parts A and B.[53]

---

[50] Public Law 95-480, signed Oct. 18, 1978.

[51] Letter to Senator Warren Magnuson, chairman, Subcommittee on Labor-HEW Appropriations, from Senator Lawton Chiles, May 12, 1978. See following section on similar legislation advanced by Senator Chiles and others in the Older Americans Act Amendments of 1978. The intent of advancing similar demonstration programs in two agencies, the Health Care Financing Administration and the Administration on Aging, was to encourage joint activities and coordination between the two agencies. HCFA staff and AOA staff serve together on joint reviews of demonstration proposals made to both agencies. The joint activities are meant to encourage both agencies to bring to bear their own special expertise in demonstrating programs which can answer questions of both service delivery efficiency and cost effectiveness.

[52] H.R. 13097, the Medicare Amendments of 1978. The bill also contained amendments to expand medicare payments for services provided by community mental health centers and inpatient services of licensed clinical psychologists, as well as chiropractic services. For a full discussion of proposals considered by the House see "Proposed Amendments to the Medicare Program," Committee Print No. 95-92, Subcommittee on Health of the Committee on Ways and Means, U.S. House of Representatives, Aug. 4, 1978.

[53] H.R. 5285, the Medicare-Medicaid Administrative and Reimbursement Reform Act. The Senate bill would also have allowed small hospitals with 50 beds or fewer to use empty acute-care beds for long-term care needs without requiring a hospital to establish a separate section for this purpose. The bill also contained measures to encourage more physicians to accept assignment on medicare claims through administrative improvements in the billing and payment process and would have required the adoption of a uniform claims form for medicare and medicaid.

Agreement on the two bills, however, was not reached. It is expected that a number of these provisions will be reconsidered during the 96th Congress.[54]

C. The Older Americans Act Breakthrough

The Comprehensive Older Americans Act Amendments of 1978 contain a number of provisions stressing a much broader commitment by the network of State and area agencies on aging to the development of community-based systems of long-term care.[55]

Senators Lawton Chiles and Pete Domenici, members of this committee, introduced bills early in the year to strengthen the act's commitment to long-term care services development.[56]

After a series of hearings on the "alternatives" issue,[57] Senator Chiles stressed the important role already played by Older Americans Act programs in the development of community-based long-term care services. At the same time, however, he emphasized that medicare, medicaid, and title XX programs must all be drawn upon to fashion the flexible programs which are needed to respond to changing needs.

> The Older Americans Act could perform a vital role in what could become a transition period leading to lessened dependence upon institutional care and the development of genuine, community-based care and support systems . . . Many experiments along these lines are already taking place under the Older Americans Act, sometimes tapping other funding sources. If all these pilot efforts are to lead anywhere, we have to think more clearly in terms of national strategies for national purposes. At a minimum, a deeper involvement by all of the aging network in speeding up this process is called for. . . .[58]

In introducing S. 2609, Senator Domenici stressed:

> This legislation will grant AoA the authority to create a number of model long-term care centers. These centers will be located within selected AAA's that can demonstrate that they have the ability to assume these additional functions: Assess an individual's need; develop a plan of care; arrange for the necessary and appropriate services; monitor, evaluate, and reassess the situation as circumstances change; maintain rec-

---

[54] The large number of bills which had to be considered by both the House and the Senate in the last days of the 95th Congress, and major differences between the House and Senate versions of the medicare amendments made it impossible to reconcile the two bills before the 95th Congress adjourned. The Senate-passed bill contained a controversial hospital cost containment measure which had not been passed by the House. (See p. 43 of this report for a discussion of this legislation.) The House-passed bill contained a number of medicare liberalizations which had not been passed by the Senate.

[55] Public Law 95-478. See chapter XII of this report for additional discussion of the 1978 Amendments to the Older Americans Act.

[56] S. 2967 introduced by Senator Chiles on Apr. 20, 1978. S. 2969, introduced by Senator Church on Apr. 20, 1978, contained similar provisions. S. 2609, introduced by Senators Domenici, Percy, Brooke, Dole, and Schmitt on Feb. 28, 1978.

[57] "Health Care for Older Americans: The 'Alternatives' Issue," parts 1 through 8, hearings before the Senate Special Committee on Aging, U.S. Senate. Senator Lawton Chiles chaired hearings in Washington, D.C., on May 16 and 17, 1977, June 15, 1977, and Sept. 21, 1977, and a hearing in Tallahassee, Fla., on Nov. 23, 1977; Senator John Glenn chaired a hearing in Cleveland, Ohio, on July 6, 1977; Senator Edward Brooke chaired a hearing in Holyoke, Mass., on Oct. 12, 1977; Senator Pete Domenici chaired a hearing in Washington, D.C., on Apr. 17, 1978.

[58] Statement, Senator Lawton Chiles, Congressional Record, U.S. Senate, Mar. 1, 1978.

ords; and assist in Outreach. The model project approach should enable us to determine, over the next few years, the validity and viability of the long-term care center concept.[59]

SPECIAL PROJECTS IN COMPREHENSIVE LONG-TERM CARE

Under the 1978 Older Americans Act Amendments, grants are authorized to State and area agencies on aging, institutions of higher education, and other public and private, nonprofit organizations to develop comprehensive, coordinated systems of community long-term care. Special emphasis is to be on services designed to support alternatives to institutional living, and the assessment of need, development of a plan of care, and referral of individuals to long-term care services where appropriate.

Grant funds may be used to help support services as necessary parts of a comprehensive system, but the law stipulates that no grant funds may be used to pay for direct services which are eligible for reimbursement through medicare, medicaid, or title XX. Grant funds may also be used for training.

The law requires the Commissioner to give preference to States which have developed standards for the services to be provided and have involved either the State medicaid or title XX agency, or both, in program operation. The law also requires the Commissioner on Aging to coordinate grant activities at the Federal level with other departments and agencies involved in the development of long-term care services development.

No funds had been appropriated for the special projects by the end of the year. Public Law 95-482, however, continues funding for the Administration on Aging's research and demonstration projects at the fiscal year 1978 funding level of $15 million. A portion of these funds may be used to initiate projects similar to those authorized under this special section.

OTHER PROVISIONS

The 1978 amendments also require the Commissioner on Aging to develop planning linkages with local health systems agencies. This provision was adopted in recognition of the unique opportunities which exist for area agencies on aging and health systems agencies to work closely together in the development of area plans for long-term care services.

The Commissioner on Aging is required to assess the Nation's future personnel needs for both institutional and noninstitutional long-term care and evaluate the adequacy of existing programs. The law also states the desire of Congress to have the Commissioner on Aging review and comment on all HEW activities concerning institutional and noninstitutional long-term care services development.

IV. VISION CARE AND A GRAYING POPULATION

More Americans are encountering vision loss simply because they are living longer. A soon-to-be-released study by the American Foundation for the Blind states that by the year 2000 there will be 1.5 million older Americans with severe vision problems, a one-third increase due in just over 20 years.

---

[59] Statement, Senator Pete V. Domenici, Congressional Record, Feb. 28, 1978.

This projection, coupled with an existing blindness service delivery system described by authorities in aging and blindness as ill-prepared to serve older clients, prompted the Senate Committee on Aging to hold an August 3, 1978 hearing on "Vision Impairment Among Older Americans."

The hearing focused on several issues, including:

—Legislation intended to help visually impaired older persons to better cope with everyday life.

—The role of vision impairment of the 1981 White House Conference on Aging.

Senator Frank Church stated in his opening remarks:

> We must gear up—far better than we are now doing—to meet the special needs of those whose sight becomes less dependable with passing years, even to the extent of total blindness.

Ranking minority Member Senator Pete V. Domenici said:

> . . . with an increasing visually impaired population, we need to examine how we can strengthen existing legislation to assist visually impaired Americans to remain functionally independent.

Principal points made at the hearing were:

—The so-called "blindness system" is a fragmented structure made up of more than 700 public and private agencies, few of them operating with agreed upon goals.

—Both medicare and medicaid provide some acute care medical services to the elderly blind but practically no rehabilitation service is available.

—Rehabilitation agencies, hampered by State and Federal regulations providing for rehabilitation for employable younger persons, offer little long-term help for older persons suffering a vision loss.

—Dramatic breakthroughs in treatment have great potential for restoring low vision but, since the leading causes of blindness among the elderly often accompany the aging process, prevention of blindness and vision loss remains an elusive goal.

—Promising rehabilitation techniques for older persons exist and may become more widespread with the passage of the 1978 amendments to the Rehabilitation Act calling for support for the unique rehabilitation needs of older persons.

V. MENTAL HEALTH: NEW REPORTS, SETBACKS, AND NEW POSSIBILITIES

High priorities for meeting mental health needs of older Americans were set in three reports issued during 1978.

However, legislation to broaden medicare for such services failed to emerge from the Senate after having passed in the House.

Another bill, the Community Mental Health Act of 1978, became law and continued that program for 1 more year. But it delayed the implementation of a provision requiring special programs for older persons at community mental health centers.

An omnibus reform bill, possibly centered on recommendations from a Presidential commission, may be offered in 1979.

A. The Studies

Three major studies considering the mental health of older Americans were released during 1978.

The President's Commission on Mental Health [60] found:

> . . . depression escalates decade by decade; 25 percent of all the suicides are committed by people over 65 years of age; we face the devastating organic brain syndrome; we face all the same crises in everyday problems that people of all ages do . . . Yet, less than 3 percent of the budget of the National Institute of Mental Health has been devoted to the totality of services, training, and research on the plight of the older Americans.[61]

The Secretary's Committee on Mental Health and Illness of the Elderly [62] documents the fragmentation of services to the senior citizen:

> Although the past two decades have brought about significant actions on behalf of many of the Nations' long ignored minority groups, including the elderly, and have witnessed the enactment of several major pieces of legislation—medicare, the Older Americans Act, Community Mental Health Center legislation with specialized services for the elderly, and the establishment of an Administration on Aging, a National Institute on Aging, and a Federal Council on Aging—untold numbers of older people are essentially untouched by them, and untold more still have problems and needs to which there has been no adequate response. The mental health needs of the Nation's elderly in particular continue to remain largely ignored.[63]

The conclusions reached by both studies are similar. As summarized, they recommend:

—Preventive services to relieve human and financial costs.

—Programs to provide the elderly with opportunity to continue in community roles.

—Education and research initiatives.

---

[60] The Commission was established by Executive Order No. 11973 signed Feb. 1, 1977, to identify mental health needs of the Nation and submit recommendations on how needs can be met. Also see "Developments in Aging: 1977," pp. 76–77.

[61] Task panel reports submitted to the President's Commission on Mental Health, p. 1119. See footnote 60.

[62] The committee was established through an amendment to Public Law 94–63 sponsored by Edmund Muskie, signed into law on July 29, 1975, and extended through fiscal year 1977 by Muskie amendment to Public Law 94–640 signed into law Oct. 8, 1976. The committee was charged with making recommendations to meet the future services, manpower, training and research needs in mental health programs for the elderly. Also see "Developments in Aging: 1977," pp. 77–78.

[63] Report of the Secretary's Committee on Mental Health and Illness of the Elderly, p. 1. See footnote 62.

—Access by older persons to community services.
—Linkages between social support systems and general physical and mental health delivery systems.[64]

Medicare financing was recommended for more mental health services, but few other program recommendations were offered in regard to the elderly.[65]

The third report that addresed the mental health problems of the aged was the age discrimination study issued by the U.S. Commission on Civil Rights.[66] The Commission found low participation in community mental health programs by the over-65 population. "Older persons accounted for 10 percent of the service area population, but represented only 4 percent of the participant population." [67]

A reason for this discrepancy is lack of adequate outreach efforts on the part of community mental health centers.

> Older persons are put at a severe disadvantage when centers fail to work with agencies concerned primarily with their needs: (1) Older persons do not have the opportunity to learn what preventive measures they can take to maintain good mental health; (2) older persons are less likely to learn about services available to them when they do encounter problems; and (3) agencies concerned with older persons do not obtain the information and guidance necessary for them to provide appropriate and adequate assistance to older persons who may have mental health problems.[68]

B. LEGISLATIVE ACTION

H.R. 13097, as passed in the House, would have allowed medicare beneficiaries to seek mental health outpatient and partial hospitalization services through community mental health centers.[69]

The Senate Finance's Health Subcommittee held hearings in August to consider expanding medicare and medicaid payments to cover mental health services. Senator Herman Talmadge opened the Senate Finance Committee hearing by asking:

> There is no question that Congress is willing to provide proper coverage for necessary mental care.
>
> The question to which we hope to get answers today is—what is proper mental care?
>
> To what extent would Congress be inviting erroneous and costly new expansion in areas where in part, an individual practitioner can define an almost infinite need for care.
>
> This is an area where there are often no objective parameters. We have limited resources available for health care financing.[70]

---

[64] See President's Commission Report pp. 1119–1141; and Committee on Mental Health and Illness of the Elderly, pp. IX–X.

[65] The President's report recommended the expansion of financing for mental health services by using medicare. See later discussion on attempts in the 95th Congress to liberalize funding.

[66] The Age Discrimination Study, a report of the U.S. Commission on Civil Rights, December 1977. Also see *Developings in Aging: 1977*," pp. 161–172 and chapter XI of this volume.

[67] See report cited in footnote 66, p. 12.

[68] See report cited in footnote 66, p. 13.

[69] Section 7 of the bill. Amendments of the Social Security Act, section 1812(a). Passed the House, Sept. 18, 1978, 398 to 2. Referred to Senate Finance Committee, Sept. 21, 1978.

[70] "Proposals to Expand Coverage of Mental Health Under Medicare-Medicaid," hearing of the Subcommittee on Health of Committee on Finance, 95th Congress, Aug. 18, 1978.

The Finance Committee did not, following the hearing, meet to consider the House-passed bill.

The Community Mental Health Amendments of 1978[71] delayed the implementation of provisions of the 1975 amendments[72] which required federally funded centers to have programs for the elderly. The combination of the delay and the 1-year authorization may discourage the development of mental health programs for the aged.[73]

The Community Mental Health Act was extended for only 1 year. Senator Harrison Williams explained:

> . . . the complexities of current law have created problems for those administering the programs at the local, State, regional, and Federal levels. And difficult questions have been raised regarding the structure and financing of the centers, as well as the range and quality of delivered services. . . . Such an extension would take fully into account the important recommendations recently made to the President by his Commission on Mental Health.[74]

C. Possibilities for 1979

President Carter will probably send a mental health reform bill to Congress early in 1979. The legislation may follow the lines recommended in the report of the President's Commission on Mental Health.[75] Seven goals are stated in an early discussion of the bill:

—Assuring accessibility for the general population to appropriate and effective mental health services which are acceptable quality and provided in an efficient manner.

—Assuring the availability and accessibility of community based mental health services for those most in need and assisting these persons in obtaining other health, rehabilitative, residential, legal, social and supportive services as they may require.

—Assuring that service systems give priority to the developments of appropriate services in unserved or underserved and inappropriately served populations.

—Minimizing unnecessary or inappropriate hospitalization of persons with mental disorders.

—Assuring that persons requiring long-term residential care due to mental illness or disability receive such care in the least restrictive and most "normal" setting possible.

—Assuring that the basic rights of current and potential patients/clients in all mental health systems are protected through internal advocacy efforts.

—Improving the capacity of the mental health system and of society generally to promote mental health, prevent mental illness and to minimize the consequences of mental illness when it does occur.[76]

---

[71] Public Law 95–622, signed by the President Nov. 9, 1978. See Congressional Record, Oct. 14, 1978, pp. S19291–19300.

[72] Public Law 94–63, 94th Congress, July 29, 1975.

[73] S2450, section 104(a)(1)(B)(iii).

[74] Senator Harrison Williams, Congressional Record, June 26, 1978, pp. S9716–9717.

[75] See report sited in footnote 61, pp. 12–55.

[76] Detailed specifications for the Community Mental Health Systems Act, Draft, Dec. 15, 1978.

D. NIMH–AoA Joint Session

The National Institute of Mental Health and the Administration on Aging held a joint training session late in 1978 to bring the aging and mental health networks together to work on common problems. The goals of the session were:

—Improve cooperation and coordination between the two networks.

—Provide information on the interactive role of mental health services and other social health services.

—Provide information on models of coordination between the Community Mental Health Centers and the aging network in order to develop a continuum of care.

—Provide a forum for Federal, State, and local officials to meet and discuss the organization and delivery of mental health and related services.

—Identify gaps in services between the mental health and aging systems.[77]

More than 50 people attended the first session in suburban Washington. NIMH and AoA plan to have additional sessions during 1979 by region throughout the country to encourage dialog between local providers of mental health and aging services.

VI. NATIONAL HEALTH INSURANCE AND THE ELDERLY

A new round in the efforts to provide a comprehensive national health program to all Americans was set in motion during 1978. The Carter administration announced a set of principles[78] in July to guide it in preparing a bill for introduction in 1979. Senator Edward Kennedy and the committee for a national health insurance (a coalition of labor, consumer, and religious organizations) put forward their own outline for a national health insurance plan in early October,[79] but no bill is expected until the 96th Congress.

Neither the administration's principles nor the Kennedy proposal would incorporate a long-term care policy for the eldery, which would remain in modified versions of medicare-medicaid.

---

[77] National Institute on Aging and the Administration on Aging conference invitation. Information memorandum AoA–IM–79–2, Oct. 16, 1978, p. 1.

[78] Presidential directive/DPS–3 to the Secretary of HEW, July 29, 1978: (1) The plan should insure that all Americans have comprehensive health care coverage, including protection against catastrophic medical expenses. (2) The plan should make quality health care available to all Americans. It should seek to eliminate those aspects of the current health system that often cause the poor to receive substandard care. (3) The plan should assure that all Americans have freedom of choice in the selection of physicians, hospitals, and health delivery systems. (4) The plan must support our efforts to control inflation in the economy by reducing unnecessary health care spending. The plan should include aggressive cost containment measures and should also strengthen competitive forces in the health care sector. (5) The plan should be designed so that additional public and private expenditures for improved health benefits and coverage will be substantially offset by savings from greater efficiency in the health care system. (6) The plan will involve no additional Federal spending until fiscal year 1983, because of tight fiscal constraints and the need for careful planning and implementation. Thereafter, the plan should be phased in gradually. As the plan moves from phase to phase, consideration should be given to such factors as the economic and administrative experience under prior phases. The experience of other Government programs, in which expenditures far exceed initial projections, must not be repeated. (7) The plan should be financed through multiple sources, including Government funding and contributions from employers and employees. Careful consideration should be given to the other demands on Government budgets, the existing tax burdens on the American people, and the ability of many consumers to share a moderate portion of the cost of their care. (8) The plan should include a significant role for the private insurance industry, with appropriate Government regulation. (9) The plan should provide resources and develop payment methods to promote such major reforms in delivering health care services as substantially increasing the availability of ambulatory and preventive services, attracting personnel to underserved rural and urban areas, and encouraging the use of prepaid health plans. (10) The plan should assure consumer representing throughout its operation.

[79] 124 Congressional Record 16813 (Oct. 2, 1978).

A. EXTENT OF THE PROBLEM

The administration and the Committee for National Health Insurance agree that the country needs a national health program, a position which several national organizations on aging have also strongly supported.

Among the arguments advanced for a NHI plan are:

—Twenty-four million Americans have no public or private health insurance whatsoever.

—Eight million of these have incomes below the poverty line.

—At least 88 million Americans have no insurance protection against catastrophic medical expenses.

—Medicare and medicaid do not reach all older Americans or the poor, nor pay for all needed services.

—More than 49 million Americans live in medically underserved areas.

—There are too many unnecessary hospital beds, and too few physicians delivering primary care.

—The health care industry is inefficient and anticompetitive.

—The poor and elderly often receive "substandard" care in our two-class delivery system.[80] (See following illustrations.)

B. WHAT IS TO BE DONE?

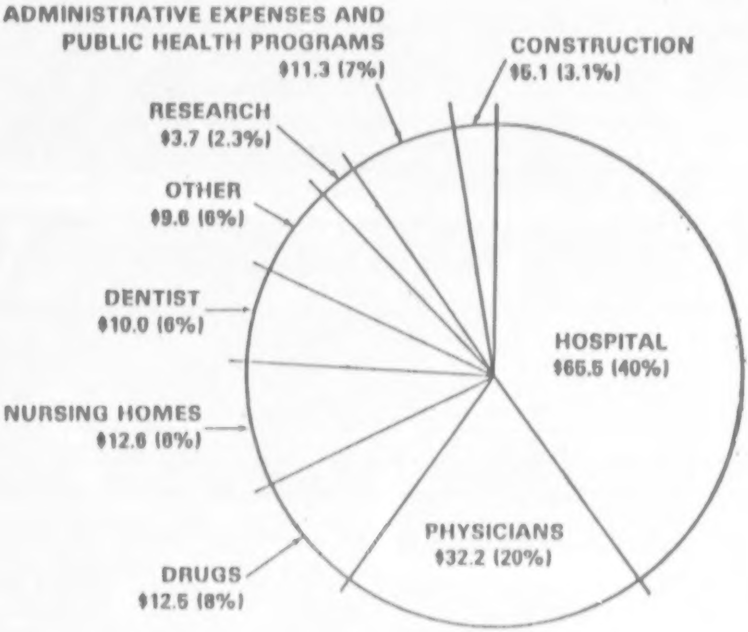
The administration position was presented by HEW Secretary Joseph Califano on July 29, 1978, after 1½ years of study.[81]

---

[80] Materials distributed by Secretary Califano July 29, 1978.

[81] In April 1977, HEW formed a 29-member public Advisory Committee on National Health Insurance issues. For the next 11 months the committee conducted site visits to various communities in this country and Canada to get a better feel for the health care financing and delivery system. A series of NHI briefing papers were prepared by HEW staff and presented to the committee. The committee adjourned in February 1978 without making any recommendations about the direction of NHI. The briefing papers included the following topics: Overview of NHI issues, discussion paper on benefits, discussion paper on Government delivery of health services, discussion paper on cost-sharing and national health insurance discussion paper on reimbursement issues, discussion paper on national health insurance cost estimation methodology, discussion paper on administration of NHI, discussion paper on financing national health insurance, discussion paper on delivery system reform under NHI, and four prototype plans discussed by the committee: quasi-public corporation target plan, consumer choice health plan and publicly guaranteed health protection. These are available through the Government Printing Office.

THE HEALTH CARE INDUSTRY: WHO RECEIVES THE PAYMENTS (FY 77)



TOTAL: $162.2 BILLION

THE HEALTH CARE INDUSTRY: THE NATION'S HEALTH BILL IS PAID FOUR WAYS

PREMIUMS → PRIVATE HEALTH INSURANCE $45 BILLION

FEDERAL, STATE AND LOCAL TAXES → GOVERNMENT PROGRAMS $68 BILLION

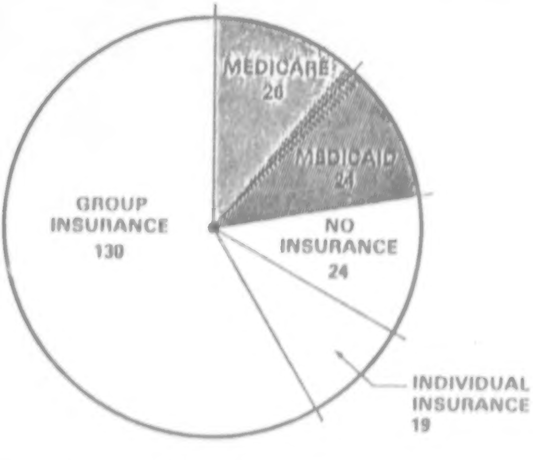
OUT-OF-POCKET → INDIVIDUAL PAYMENTS $43 BILLION

PHILANTHROPY AND COMPANY HEALTH SERVICES $6 BILLION

TOTAL: $162 BILLION

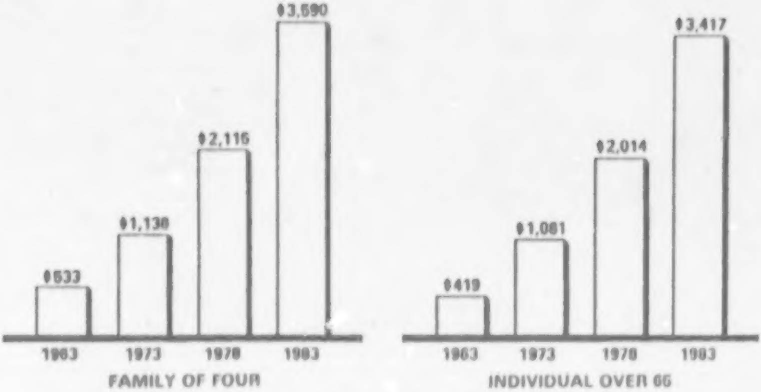
CURRENT INSURANCE COVERAGE:* PUBLIC AND PRIVATE

(Millions of Persons: FY 78 Projections)



*ANY COVERAGE -- EVEN VERY LIMITED AND INADEQUATE

Problem —
RISING HEALTH CARE COSTS: INDIVIDUAL PERSPECTIVE



AVERAGE COSTS OF HEALTH CARE

The administration's principles speak to comprehensive, quality of care for all Americans; freedom of choice of provider; strong cost controls and greater efficiency in phasing in benefits and population groups over a period of time; employer-employee contributions; Government funding and cost-sharing by patients; a role for the private insurance industry; delivery system reform; and consumer representation. The pivotal principles are:

> The plan will involve no additional Federal spending until fiscal year 1983, because of tight fiscal constraints and the need for careful planning and implementation. Thereafter, the plan should be phased in gradually. As the plan moves from phase to phase, consideration should be given to such factors as the economic and administrative experience under prior phases. The experience of other Government programs, in which expenditures far exceed initial projections, must not be repeated.[82]

This reportedly represents a compromise. The President's economic advisers argued that the Federal Government could only afford a program for the poor and those with catastrophic illnesses; HEW and the domestic policy staff, however, argued that a broad program which insures basic benefits to all Americans is the only effective lever on runaway health costs.[83]

On October 2, 1978, Senator Kennedy unveiled the proposal of the Committee for a National Health Insurance,[84] which would impose immediate cost controls on the hospital industry when enacted and would extend basic benefits to everyone 2 years after enactment.

---

[82] See footnote 78.

[83] 124 Congressional Record 16813 (Oct. 2, 1978).

[84] Inglehart, John K., "National Health Insurance—Carter's Conflicting Promises," National Journal, 1212, July 29, 1978.

Under the President's principles phasing in of benefits and/or population groups would occur only if certain economic conditions were met and might require congressional action on each occasion.

Under the Kennedy proposal, every U.S. resident would be issued a health insurance card entitling that person to basic benefits: preventive care, inpatient hospital services, physician services, home health services, X-ray and lab services, and full coverage for catastrophic illness costs. Older Americans would have essential prescription drugs reimbursed by medicare.

However, long-term care services, including nursing home care, would not be included in the basic benefit package. Instead, these services would be the responsibility of each State.

Provider discrimination against patients on the basis of source of payment, race, or national origin would be prohibited.

C. PAYING FOR NATIONAL HEALTH INSURANCE

The Kennedy proposal relies on the following:

—*For the employed and self-employed.* The mandated benefits would be financed through employer and employee private health insurance premium contributions. This is generally the case now. Under this plan the private insurers would be subject to stringent Federal regulations.

—*For the elderly.* The benefits would be paid for by social security payroll taxes that now finance medicare part A. This would be supplemented by Federal revenues.

—*For the poor and unemployed.* The Federal Government would pick up the costs.

—The medicaid program would be "federalized" for the services mandated in the national insurance package, thus relieving the States of the financial burden.

The Carter plan.—At this time, the Carter proposal does not have a specific financing mechanism, although one of the principles does discuss a mixture of public and private financing. Costs would also be offset by aggressive cost containment and control of inflation in the health care sectors.

D. IMPLICATIONS FOR OLDER AMERICANS

Neither the Carter administration's principles nor the Kennedy plan endorse special services for older Americans. Both indicate that medicare and medicaid would continue somewhat in their present fashion. The Kennedy proposal does do away with the coinsurance and deductible segments which have long been a burden to older Americans in the medicare program. Further, plans call for coverage of catastrophic medical expenses, which would be beneficial for the aged since they tend to spend more days in the hospital than other segments of the population. Coverage of all prescription drugs in the Committee for National Health Insurance's plan would be of special importance to the elderly.

As discussed earlier, long-term care is not included in either proposal. The Kennedy supporters indicate that nursing home, adult day care, and other forms of long-term care would still be available through the States such as are now available in the medicaid programs. Moneys for long-term care would be available at the same match as States now have under the medicaid program, with a requirement that services currently offered could not be reduced. States would have an incentive to continue and perhaps expand the long-term care programs since total State expenditures would be reduced with the federalization of the mandated national health care package.

The exclusion of nursing home services may be attributed to the large expense. Currently, 38 percent of medicaid expenditures go for nursing home care.

E. STRONG SUPPORT FROM ORGANIZATIONS

Both the National Council of Senior Citizens and the American Association of Retired Persons/National Retired Persons Association support the principles put forward by Senator Kennedy.

William Hutton, NCSC executive director said:

> . . . There is no dollar amount that accurately reflects the sense of security an older person gains as a result of knowing that if he or she should become ill, the money will be there to pay for it . . .[85]

Cyril Brickfield, AARP/NRTA executive director said:

> . . . The fact is that through its encouragement of competition among providers of health care, your proposal is far more uniquely American and far more consistent with free enterprise than our present system of "monopolized medicine" . . . Another reason to consider NHI is the failure of medicare to adequately meet the needs of older Americans . . .[86]

NCSC and AARP/NRTA said they will work with Senator Kennedy and his subcommittee on health to get legislation through Congress during the next session.

F. HEALTH SUBCOMMITTEE HEARINGS

Hearings on national health insurance began on October 9, 1978, in Washington. Subsequent hearings have been held in Detroit, California, Illinois, West Virginia, and Denver. Comparisons at the Detroit and Washington, D.C., hearings indicated that in Canada, which has a publicly financed health plan, all medically incurred expenses were covered while people with similar problems in this country were without adequate resources.

On the basis of the hearings, as well as other public discussion, a national health insurance bill will probably be introduced during the 96th Congress. The Kennedy and Carter proposals are not the only ones being discussed. Representative Ron Dellums of California has called for a national health service program which would change the financing and method of delivering health care to all Americans. The

---

[85] Testimony before the Senate Committee on Human Resources Subcommittee on Health and Scientific Research on The National Health Insurance Act of 1979. For the National Council of Senior Citizens, Oct. 10, 1978.

[86] In support of the National Health Insurance Act of 1979. For the National Retired Teachers Association and the American Association of Retired Persons, Oct. 10, 1978.

98

Dellums proposal would establish a publicly controlled health service—financed primarily by Federal income taxes—that employs health workers on a salaried basis to provide comprehensive health services. Advocates of a national health service argue that a national health insurance program would only make things worse than they already are, since it would put money into an existing health care delivery system without making fundamental changes necessary to assure equal access to quality care.

The American Medical Association has indicated that they may develop a plan of their own.

> At the 1978 interim meeting the house of delegates adopted a resolution calling on the board to sponsor, if necessary, legislation to require minimum standards of adequate benefits for health insurance policies, with deductible and coinsurance; to include a system of uniform Federal, State, and local government benefits for those who cannot provide for their own medical care; to make catastrophic insurance coverage by the private insurance industry available through a nationwide program; and to provide for administration at the State level with national standardization through Federal guidelines.[87]

All of the proposals are likely to be discussed during the next year as health care costs continue to rise.[88]

---

[87] American Medical Association statement on national health insurance, interim statement, Jan. 22, 1979.

[88] Senator Russell Long introduced several catastrophic health insurance bills early in 1979. Consideration of these bills and those proposed by the American Medical Association, the Carter administration, the Kennedy Health Subcommittee, and any other similar bills will be considered during the 96th Congress.

CHAPTER IV

FRAUD AND ABUSE: HOW MUCH?

Mounting evidence of repeated patterns of fraud and widespread prevalent mismanagement in key health care programs for older Americans produced several actions by the Congress and the executive branch during 1978:

—The Senate Committee on Aging heard witnesses urge a substantially strengthened effort to aid the establishment and operation of the State fraud control units called for by the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977. A legislative effort in this direction fell short of final legislative action during the close of the 95th Congress.

—Patterns of medicare and medicaid provider ownership subterfuge resulting in inflated medicare and medicaid reimbursement had resulted in 1977 legislation authorizing stringent ownership disclosure. The Department of Health, Education, and Welfare produced draft regulations in late 1978 to implement these requirements.

—The Inspector General of the Department of Health, Education, and Welfare called for new initiatives to strengthen detection, investigation, and prosecution of fraud and abuse in health care delivery; he also set goals for the tightening of the management of Federal- and State-controlled health care reimbursement practices. Toward that end, Secretary Joseph A. Califano convened the first National Conference on Fraud, Abuse, and Error in HEW, calling for a sharpening of estimates of these losses along with more precise targeting of Federal and State resources to reduce fraud and mismanagement.

President Carter, in his address to more than 1,000 State and local officials at the December 13 and 14 Conference on Fraud, Abuse, and Error, said that Secretary Califano had pledged to save $1 billion during the current fiscal year by eliminating waste and fraud.

Singling out "senior citizens deprived of medical services" among those who are victimized by waste in HEW programs, President Carter called for overhauls in the management of these programs, including a directive to OMB Director James McIntyre and HEW Secretary Joseph A. Califano, Jr., to streamline Federal eligibility programs for public assistance programs.

The General Accounting Office determined that the medicaid management information system (MMIS), a medicaid management tool, falls well below the performance standards required by law. Thus lowering a medicaid detection of fraud and abuse by providers and recipients.

I. THE ESTIMATES

Losses due to fraud, abuse, and waste in the Federal share of medicaid, possibly running as high as 27 percent of the Federal expenditures in this program, are the single largest loss in HEW programs. Medicare losses are the second largest.

In fiscal year 1977, as much as $2.6 billion of the total Federal medicaid expenditures of $9.8 billion were lost through errors, faulty management systems, and fraud. Losses because of these same problems run as much as $2.2 billion of the total medicare expenditures of $21.9 billion in fiscal year 1977.

These losses were reported in the March 31, 1978, First Annual Report of the Department of Health, Education, and Welfare's Inspector General. The Inspector General's self-described "best estimates" of these losses are based on an inventory of information revealed in GAO and HEW audits, HEW quality control surveys, and congressional hearings—including Senate Committee on Aging hearings on fraud and abuse.

The report stresses that the summary is based on incomplete inventories of these programs and that it is virtually impossible to distinguish sharply between fraud, abuse, and waste since each category of loss may involve all three problems.

However, the Inspector General concludes that, in spite of these limitations, the data are reasonable estimates and may well be conservative measures of the total loss.

A. Medicaid Losses

HEW analysis of the $2.6 billion Federal share loss attributed to medicaid shows estimates ranging from $855 million to nearly $1.2 billion, due to error and faulty management systems, such as payments to ineligible beneficiaries, overpayments, and failure to collect third party payments.

The second largest loss, pegged at $802 million, results from unnecessary surgery and hospitalization, excessive hospital bed capacity, excessive physician costs, and unnecessary X-rays.

Outright fraud costs the Federal share of the medicaid program as much as $653 million. "Medicaid mill" operations and abusive clinical laboratory practices—both documented by investigations conducted by this committee—account for the chief losses in this category.

Losses attributable to fraud are probably understated since, according to the Inspector General, no analysis was made of the operations of pharmacists, home health agencies, and other health care providers. In addition, the report contends that some of the losses carried under the category of unnecessary costs may, upon further analysis, be the result of fraudulent or abusive practices of health care providers.

B. Medicare Losses

Over $2.2 billion of the $21.9 billion estimated fiscal year 1977 medicare expenditures was reportedly due to error, faulty management, and chiefly to support excess hospital bed capacity.

While the $15 million loss estimate from fraud and abuse is the smallest category of medicare loss, it is, according to the Inspector

General, attributable entirely to fraudulent and abusive practices by some providers in the nursing home industry: primarily kickbacks to suppliers, deceptive real estate practices, and the filing of false cost reports.

Here too, the losses may be understated because no analysis is made of medicare providers other than hospitals, nursing homes, and physicians.

FRAUD, ABUSE, AND WASTE—THE IMPORTANT DISTINCTION

With evidence of such substantial losses of tax dollars in these programs, this committee expanded its series of hearings on long-term care issues to include a focus on national and State efforts to curb fraud and abuse in health care programs for older Americans.

Expert witnesses have emphasized that fraudulent practices are often undertaken in the absence of the effective management necessary to detect the willful misrepresentation involved in fraud. Time after time, this committee has been told that effective management systems and aggressive prosecution are essential deterrents to these operations and that proper attention to the distinctions involved in fraud, abuse, and waste is necessary for the proper targeting of these resources.

For the purpose of rough definition of these practices, the Inspector General's report makes these distinctions:

—*Fraud* is defined as the obtaining of something of value, unlawfully, through willful misrepresentation.

—*Abuse* covers a wide variety of excessive services or program violations, and improper practices not involving prosecutable fraud.

—*Waste* is the incurring of unnecessary costs as a result of deficient practices, systems, or controls.

II. THE STATE FRAUD CONTROL UNITS

This committee has closely monitored the progress of the State fraud control units called for in the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (Public Law 95–142).

Section 17 of this law provides 90 percent Federal matching in fiscal years 1978 through 1980 for the costs incurred in the establishment and operation of these units.

On July 25, Senate Committee on Aging Chairman Frank Church conducted a hearing to review the implementation of section 17 fraud control units. The major questions before this inquiry were:

—The rate of progress in the creation of these units.

—The steps being taken by HEW to encourage the formation of the units.

—The status of the units after October 1, 1980, when the Federal share of funding expires.

Frank S. Beal, Deputy Administrator for Operations of the Health Care Financing Administration, told the committee:

> . . . section 17 is one of the most important provisions of Public Law 95–142. This section, which provides an incen-

---

[1] Department of Health, Education, and Welfare, Office of the Inspector General, "Annual Report," March 31, 1978, p. 1.

tive of 90 percent, Federal matching funds to States that establish independent medicaid fraud control units, recognizes that the State is the most appropriate investigator and prosecutor of medicaid fraud.[2]

In reviewing the current status of applications for the program Mr. Beal stated:

> At the present time, there are nine certified State fraud control units, located in Louisiana, Alabama, Michigan, New Mexico, Connecticut, Rhode Island, New Jersey, Washington State, and Colorado.
>
> In addition, we have received applications from 11 other States and anticipate receiving many more this year. The 20 States whose units have been certified or whose applications are being reviewed for certification, account for 72 percent of medicaid expenditures. We expect 35 units to be certified by the end of the year covering nearly 85 percent of medicaid expenditures.[3]

However, as of December 1978 only an additional 10 States—Idaho, Massachusetts, New York, Pennsylvania, Wisconsin, California, Hawaii, Vermont, Ohio, and Nebraska—were certified making a total of 19 participants in the program.

Noting the problems in the certification process, Mr. Beal told the committee:

> . . . our most frequent problem has been in reaching agreement with States on the level of funding. Some States have had great difficulty supporting their funding requests, and the resulting need to negotiate has delayed the certification of some fraud units.[4]

The committee called on Charles J. Hynes, New York's special prosecutor for nursing homes, health, and social services, to testify on New York's pioneering efforts as a prototype fraud control unit. During the July 25 hearing, Hynes stated:

> With respect to my own State's application, after the promulgation of the regulations and the clarifying of various jurisdictional concerns, New York submitted its application to the Department of Health, Education, and Welfare almost 3 months ago. Having been cited by Congress as the "model agency" for these units, we had hoped for a rapid and affirmative response. This response has not been forthcoming.[5]

In view of certification delays and the October 1, 1980, expiration date for the Federal share of funding, Chairman Church asked whether these units would have the full 3 years of operation intended by Congress. Charles J. Hynes replied:

> Given the difficulties in establishing or maintaining medicaid fraud control units, it appears that the investigations will actually be funded, then, for a period of 2 years, and not the

---

[2] "Medicaid Antifraud Programs: The Role of State Fraud Control Units," statement of Frank S. Beal before the U.S. Senate Special Committee on Aging, July 25, 1978.

[3] Ibid.

[4] Ibid.

[5] Testimony of Charles J. Hynes, July 25 hearing.

> 3 as was the original intent. This is not satisfactory, Mr. Chairman, when one considers the kind of investigations to which I have been referring.
>
> They are long; they are tedious; and they are difficult.[6]

In view of these problems, Senator Church introduced legislation calling for the period of Federal funding for the units to extend to October 1, 1982, to insure that States making a good faith effort toward certification would have the full 3 years of funding necessary to test this concept.

The Church amendment was made part of a package of health care amendments which failed to pass in the final days of the 95th Congress because the House refused to agree to the measure's hospital cost containment provisions.

The Church amendment, possibly in modified form, will be reintroduced during the first session of the 96th Congress.

III. MEDICARE-MEDICAID PROVIDER OWNERSHIP DISCLOSURE

Testimony before this committee documented complex interweaving of relationships among many medicare providers and subcontractors, ancillary service providers, and other health care facilities often resulting in substantial overreimbursement by medicare and medicaid.

These hearings and investigations helped make the case for congressional approval of the provider ownership disclosure requirements under the Medicare-Medicaid Anti-Fraud and Abuse Amendments.

The Health Care Financing Administration published draft regulations implementing these requirements on August 4, 1978. Secretary Joseph Califano commented:

> These rules would give us an important new tool with which to ferret out evidence of fraud and abuse in those important programs and prosecute offenders. They will help us identify situations in which self-dealing, interlocking directorates, or other arrangements allow providers to make excessive profits. In addition, the existence of this requirement will serve as a deterrent to those who would use obscure business arrangements to defraud taxpayers.[7]

Committee Chairman Frank Church and ranking minority member Pete V. Domenici wrote to Secretary Califano expressing reservations about the draft regulations. Foremost among the problems addressed by the Senators is the fact that the draft regulations require routine disclosure of facility ownership while not applying the same standard to business relationships with subcontractors, ancillary services, and interests in other health-related facilities.

IV. ADMINISTRATION INITIATIVES

In addition to offering its inventory of fraud and other program losses, as described in the beginning of this section, the first annual report of the HEW Inspector General, dated March 31, 1978, also discussed activities underway or recommended to combat these losses.

---

[6] Ibid.

[7] HEW news release for Monday, Sept. 11, 1978.

Among the programs now operating are:

1. Project Integrity—a computer-based effort to detect abuses by physicians and pharmacists in every medicaid State and the District of Columbia. Special scrutiny is directed toward false claims for services not rendered, inflated billings, substitution of generic for brand name drugs, and overbillings for laboratory services as well as simply erroneous billing. The next series of Project Integrity initiatives will involve an intensive effort, in selected States, to examine the practices of dental service providers and clinical laboratories.

2. Audit Agency reports will concentrate on HEW principal operating components in order to analyze the implementation of audit recommendations for more effective program management.

The audit agency's fiscal year 1979 work plan allocates one-third of the staff resources of the Office of the Inspector General to audits of programs in the health services field with known or potential patterns of fraud and abuse or management problems.

The Inspector General also recommended a 100-percent increase in the staffing of the office of investigations in order to deal with the steadily increasing workload. The September 14, 1978, memorandum of understanding between the office of program integrity and the Inspector General, makes the office of investigation chiefly responsible for criminal fraud investigation within HEW programs.

CRIMINAL FRAUD INVESTIGATIONS AND THE DEPARTMENT OF JUSTICE

Section 4(c) of the two Medicare-Medicaid Anti-Fraud and Abuse Amendments requires that the Inspector General, as part of his annual report to Congress, provide an analysis of medicare and medicaid criminal fraud cases referred to the Department of Justice. One element of the 1978 report anticipates a sharp increase in the number of referrals:

> . . . the results of Project Integrity and additional initiatives of a similar nature will fall in part, into the hands of the U.S. attorneys. There is little question that the U.S. attorneys have evinced considerable interest in medicare and medicaid fraud prosecutions, and the stress on white-collar crime being placed by the Attorney General should insure that that interest does not flag. It is crucial, however, that there be continued emphasis on the training of younger assistant U.S. attorneys in the investigation and prosecution of program fraud.[8]

RESEARCH NEEDS

The Inspector General has also outlined long-range research initiatives in the health care field which are particularly noteworthy in view of the known patterns of fraud and abuse.

In 1979 and 1980, the concentration of Project Integrity initiatives are scheduled to focus on home health care agencies, nursing homes, and hospitals.

---

[8] Office of the Inspector General, annual report, p. 31.

NURSING HOMES

Approximately 38 percent of medicaid expenditures are devoted to long-term care for older Americans. Three specific antifraud and abuse projects will be undertaken in this area:

—In accordance with section 1905(a) of the Social Security Act, an onsite audit of each participating provider must be conducted over the next 3 years.

—Under the disclosure requirements of Public Law 95–142, the Inspector General's office will begin to develop a data base of provider ownership.

—Research audits are now underway in a selected number of nursing homes which show high cost patterns as a further means of perfecting techniques for identifying problem areas.

HOME HEALTH CARE

The most significant recent growth area in medicaid expenditures is for services rendered by home health care agencies. The first annual report of the Inspector General and investigations and hearings before this committee have surfaced a number of operational patterns indicating opportunities for fraud and abuse. Public Law 95–142 mandates that the Secretary of Health, Education, and Welfare report to Congress on the growing problems within this industry. The Office of the Inspector General is participating in this study by identifying methods to detect fraud, abuse, and waste.

HOSPITALS

The second largest category of medicaid expenditures go for payments to hospitals. The Inspector General is now developing a national initiative to study patterns of payments within the hospital system. In preparation, HEW has contracted for a 2-year study with the office of the New York State Special Prosecutor for Nursing Homes, Health, and Social Services to analyze and investigate 25 New York hospitals. The project is scheduled for completion in October 1979. The Inspector General's report notes:

> This effort is off to an excellent start and the first indictment in Suffolk County has just occurred involving alleged kickbacks from suppliers and alleged theft of funds by the principal owner.[9]

The provider recently entered a guilty plea to the indictments and is now making restitution of about $1.2 million.

V. THE GAO ASSESSMENT(S): THE SECRETARY'S CONFERENCE ON FRAUD, ABUSE, AND ERROR[10]

A 1978 General Accounting Office report, requested by the Permanent Subcommittee on Investigations of the Senate Committee on

---

[9] Ibid., p. 39.

[10] Report of the Comptroller General of the United States, "Attainable Benefits of the Medicaid Management Information System Are Not Being Realized," U.S. General Accounting Office, Sept. 26, 1978.

Governmental Affairs, concludes that the surveillance and utilization review systems of medicaid management information system (MMIS) designed to detect potentially fraudulent activities, in Michigan, Ohio—both ranking in the top 10 of medicaid spenders—and Washington, are not effective.

While the surveillance and utilization review system of MMIS does not stand alone in determining medicaid utilization, it is a key element in the effective use of other methods of review used to detect potential fraud and abuse in the medicaid financed health care system. At this time 17 States have certified MMIS operations.

The GAO report criticizes HEW's system design and approval process for MMIS pointing out that, in the present state of development, this key subsystem is ineffective in identifying potential fraudulent or abusive patterns.

CHAPTER V

NEW DIRECTIONS IN NURSING HOME CARE?

> "For too long we have focussed on procedures and neglected concern for the patient."
>
> —Robert Butler, Director,
> National Institute on Aging.[1]

National concern about nursing home care is often centered on costs. The Congressional Budget Office estimates total Federal, State, and local expenditures for such care are $7.2 billion, or 59 percent of the total $12.6 billion cost.[2]

This committee continues to be concerned about how public and private dollars are being spent, particularly in terms of the quality of care provided.[3]

These two concerns—the high cost of long-term care, as well as the quality of care provided—remained in the forefront in 1978. Among the key developments:

- —Several States and the Federal Trade Commission have begun investigations into such issues as patients' rights, full disclosure of nursing home charges, and eviction of patients when public support is withdrawn.
- —A coalition of private citizens reported that nurses aides in long-term care facilities are overworked and undertrained.

I. THE HEW REVIEW AND HEARINGS

A long-sought initiative was begun on June 8, 1968, by the Health Care Financing Administration of HEW. At that time, HCFA announced that it would review and invite public comments on regulations that skilled nursing facilities (SNF's) and intermediate care facilities (ICF's) must meet to participate in the medicare and medicaid programs.

- —The Department of Health, Education, and Welfare invited and received far-ranging criticisms of current regulations under which skilled nursing home and intermediate care facilities provide care through medicare and medicaid. Repeated pleas were made for sensible, enforceable rules focused more directly on patient care.
- —Senate hearings produced new complaints about shortcomings in Federal-State rule enforcement, with special emphasis on quality of care.

---

[1] "Long-Term Care," Oct. 20, 1978, vol. 7, No. 42, p. 4.

[2] "Long-Term Care. Actuarial Cost Estimates," a CBO technical analysis paper, August 1977.

[3] A preface to "Nursing Home Care in the United States: Failure in Public Policy" said, for example, in November 1974: "Federal support of long-term care for the elderly has, within a decade, climbed from millions to billions of dollars. What is the Nation receiving for this money?" The report was issued by the Subcommittee on Long-Term Care, Senate Special Committee on Aging.

An HCFA report said:

> These regulations have been in effect for over 4 years. There is a need to simplify regulations to focus on patient care, to control the cost of care, and to achieve more effective compliance with the standards.[4]

At the hearings in five cities,[5] HCFA was praised for seeking opinions and criticized for current enforcement problems. An HCFA report summarized:

> . . . there were recurrent complaints: too much paperwork, regulations either too specific or so vague as to be unenforceable, sanctions too limited and too drastic, failure to back up regulations with adequate reimbursement for required services. *Everyone agreed that the new regulations should shift the focus of the Government's attention from the physical characteristics of facilities to the quality of care actually given to the residents.* [Emphasis added.][6]

A. THE "SPECIFICATIONS"

HCFA based its hearings on "specifications" outlining issues of concern:

(1) What minimum qualifications should be established for professional personnel who work in or with a certified skilled nursing or intermediate care facility?

(2) Should medications be administered by unlicensed and untrained personnel? Should medication aides be required to satisfactorily complete a State-approved training program? If trained medication aides are to be permitted, which agency or body in the State should approve the training program and provide overall supervision?

(3) Does the medical direction requirement insure that patients receive adequate and appropriate medical and other services on a timely basis? If not, how can the requirement be improved to be made more effective?

(4) In order to obtain adequate physician supervision of SNF patients, should we continue to require physicians to visit their patients every 30 days for the first 90 days and no less than every 60 days thereafter?

(5) Should physician extenders be utilized in SNF's and/or ICF's? These include nurse practitioners and physicians' assistants.

(6) Should SNF's and/or ICF's be required to provide or make arrangements for respiratory services for the provision of inhalation therapy?

(7) Should the facility be permitted to use nursing staff manpower pools?

(8) Should the Secretary seek statutory authority to specify which edition of the life safety code issued by the National Fire Protection Association should apply to currently certified SNF's and the SNF's initially applying for participation in medicare or medicaid?

---

[4] In its report, "New Directions for Skilled Nursing and Intermediate Care Facilities," summaries of public hearings, June–August 1978. Also see 43 FR 24873, June 8, 1978.

[5] Rockville, Md., June 27–28; Chicago, Ill., July 11–13; Washington, D.C., July 18–20; Atlanta, Ga., July 25–27; and San Francisco, Calif., Aug. 7–10.

[6] P. II of report cited in footnote 3.

Two additional considerations were suggested: (1) Revision of current procedures to require facilities to perform self-survey and submit plans for correction; and (2) extension of provider agreements from 12 to 24 months or longer.

HCFA officials provided this rationale for the proposed reliance on self-surveys:

> . . . the self-survey would be a means for getting the facility more involved in the evaluation, for having the staff and administration of the facility evaluate themselves, for reducing the survey time spent on things that do not change from one year to the next (e.g., width of halls) and for giving the staff better understanding of the standards they are expected to comply with. . . .[7]

B. Public Comments

HEW received more than 600 statements from witnesses representing providers, professional organizations, consumers, and government officials:

Self-surveys.—Individual providers support the idea of self-surveys ". . . as an excellent vehicle for improving the quality of your own employees. . . ." Consumers and the national provider organizations did not support self-surveys.

Extension of the provider agreement.—The American Health Care Association and the National Council of Health Care Services agreed that the provider agreement should be extended for those facilities that are in "substantial compliance." However, the American Association of Homes for the Aged and consumers stated that lengthening "hardly reinforces the public trust essential for insuring quality services to the elderly . . . is not warranted by conditions in all but a handful of homes across the country."

Medical direction and physician involvement.—HCFA suggested the possibility of eliminating a requirement that each nursing home employ a medical director. The American College of Nursing Home Administrators concurred saying a nurse could fulfill the role of the medical director. Consumer groups, on the other hand, want to keep the medical director.

A second concern is the frequency of physician visits. Again the providers supported the HCFA position that visits should occur at least quarterly and perhaps more frequently.

Specialized services.—The provision of physical therapy, occupational therapy, respiration therapy, dental services, and other rehabilitation services in nursing homes is often not an integral part of the regular daily activities offered to patients. Consumers and professional organizations, such as the American Dietetic Association, the National Association of Social Workers, the American Dental Association, and the American Speech and Hearing Association, argued for more specific requirements in this area.

Patients' rights.—The National Senior Citizens Law Center (NSCLC) suggested that HCFA "absolutely prohibit" nursing homes from transferring residents who exhaust their personal funds and become eligible for medicaid. Consumer groups recommended very strong patients' rights provisions, but provider groups believe that they are too difficult to administer.[8]

---

[7] Report cited in footnote 3.

Several other witnesses commented on patients' rights, including Robert Benedict, Administration on Aging Commissioner Benedict asked HCFA to require a staffing ratio in facilities of nurses and nurses' aides to patients. A second issue Benedict addressed was the abolition of the "arbitrary and artificial distinction between skilled and intermediate care."[9]

NEXT STEPS

As 1978 ended, HCFA was preparing new regulations based upon the hearings and other agency analyses. At least a 90-day comment period is to follow publication of the proposed rules early in 1979. Final regulations will be published late in the year. Implementation of the new regulations may take an additional 6 months in order to allow development of instruments to measure quality of care and train the inspectors.

C. NEW FIRE REGULATIONS

Fire prevention in nursing homes was not considered in the "specifications" by HEW, which advanced a separate set of proposed regulations for that purpose in December.[10] The fire safety provisions will become a part of the requirements for nursing homes participating in medicare and medicaid.

Five alternative proposals to the current standards are being offered:

Requiring all participating long-term care facilities to have automatic fire extinguishers.

Requiring automatic extinguishers in newly constructed or recently converted facilities.

Requiring extinguishers in all new or recently converted facilities unless the buildings are of fire-resistant construction.

Retaining the present requirements which require SNF's to meet the 1973 life safety code of the National Fire Protection Association and ICF's to meet the 1967 code.

Requiring facilities to have other measures, such as smoke detectors, special patient evacuation plans, staff emergency training or higher staff-patient ratios.

Comments on the fire safety regulations are due in early January 1979.

II. HEARINGS FOCUS ON QUALITY OF CARE

Senate hearings were called in 1978 to investigate charges of inadequate enforcement of Government regulations and lack of sufficient attention to the quality of nursing home patient care.

A. CHICAGO TESTIMONY

Senator Charles Percy conducted a hearing in Chicago on August 30, 1978, after receiving allegations from the Better Government Association and Television Station WLS–TV (an ABC affiliate) that poor conditions persisted in Chicago area nursing homes despite repeated inquiries and complaints.

---

[8] D–12–13, report cited in footnote 4. Also see "Long-Term Care," Oct. 20, 1978.
[9] "Long-Term Care," Oct. 20, 1978.
[10] P. 57166, Federal Register, Dec. 6, 1978.

Witnesses were called to testify on two subjects: (1) The apparent lack of coordination among Federal, State, and local regulations to insure quality patient care; and (2) the need to develop and fund alternatives to nursing homes in order to assure the most appropriate level of care.

BGA and WLS–TV representatives asserted that no real changes had occurred in the quality of care in nursing homes since their last investigations in 1975 and 1971. They concluded:

> . . . the major causes of failure in nursing home reforms are the lack of enforcement of existing regulations, the Federal Government's failure to develop meaningful guidelines for quality patient care, and a reimbursement system which encourages financial abuses and cost cutting at the expense of patient's needs.[11]

Nursing home administrators and State officials claimed that abuses in nursing homes and poor patient care were found in only a few homes. Additionally, they claimed that most homes were providing acceptable care. The Illinois Health Care Association, represented by Lynn May, criticized the BGA investigation:

> . . . we found a pattern in the nature of the BGA allegations, we think, that largely, although not all, many of them were based on hearsay or incomplete exposition of actual facts.[12]

Suzanne Weiss of the Accom-o-Day Adult Day Center discussed the lack of funding available in the State of Illinois for alternatives to institutional care. She described her frustrations in attempting to fund the center. Ed Stec, an HEW regional office representative, and Art Quern, director of the Illinois Department of Public Aid, agreed that regulations needed to focus more on patient care. Both felt that closing nursing homes as an answer to enforcement was too drastic a measure. Stec commended the current HEW efforts to draft new regulations. Quern pointed to efforts in Illinois to streamline the regulatory process.

Dean Jost, of Uptown Legal Services, representing nursing home patients, saw a specific Federal role to improve quality care:

> The Federal Government needs legislation requiring States which participate in the medicaid program to tie reimbursement to quality care. A certification system needs to be developed which would make it possible to rank homes by quality of care so the private consumer market would decide on what care it wanted.[13]

Four themes emerged from the Chicago hearing:

—A need for greater coordination among the regulators of long-term care facilities.

—A need for a quality measurement of patient care.

—A need for community groups or advocates to visit nursing homes.

—A need for the availability of alternatives to institutionalization.[14]

---

[11] "The Federal-State Effort in Long-Term Care for Older Americans: Nursing Homes and 'Alternatives,'" Chicago, Ill., Aug. 30, 1978.

[12] See footnote 11.

[13] See footnote 11.

[14] See footnote 11. Also see "Growing Old in America," Chicago Tribune, parts 2 and 3, discussion on nursing home abuses.

B. Washington Hearing

The Senate Subcommittee of Federal Spending Practices of the Governmental Affairs Committee also conducted hearings in July and November. Senator John Heinz, who chaired the hearings, said:

> Changing the standards as well as the enforcement procedures will not be easy, but it is necessary and vital, absolutely vital . . . if we are to improve . . . the quality of nursing home care. It may be that we need to take a fundamentally different approach to the regulation of nursing homes. At some point, if the system doesn't work, we need to stop tinkering and build a new and better model.[15]

Harold Gordon of the Maryland State Department of Health and Mental Hygiene summarized many of the witnesses' statements:

> We have fully occupied ourselves with the monitoring of conditions surrounding the physical plant, the life safety code, equipment, construction, and other tangible aspects of the nursing home industry while avoiding the main issue: patient care.[16]

The National Citizens Coalition for Nursing Home Reform and the National Senior Citizens Law Center presented testimony asking that the patients rights and regulations be given Federal attention. According to the coalition:

> The existing patients' rights regulations do not include provisions for implementation and enforcement. States such as Texas, New York, and Connecticut have dealt with the problems with State regulations.[17]

Representatives of the nursing home industry pointed out that the requirements for documentation of compliance with Federal regulations often take time away from patient care.

Roger Lipitz of the American Health Care Association and Jack MacDonald of the National Council of Health Care Services said:

> The documentation process itself is counterproductive to the work that needs to be done in nursing homes. They agreed with other witnesses who said patient care and patient satisfaction should be the major criteria for measuring home effectiveness.

III. FEDERAL TRADE COMMISSION INVESTIGATES NURSING HOME PRACTICES

The Federal Trade Commission is considering the possibility of proposing a trade rule[18] dealing with such issues as: disclosure of nursing home charges, refund policies, transfer and discharge policies, itemization of monthly bills, prohibitions against waivers of liability, and freedom of choice in the selection of pharmacies.

---

[15] "Problems in the Procedures Now Used for the Medicare and Medicaid Certification of Skilled Nursing Facilities and Intermediate Care Facilities," Subcommittee on Federal Spending Practices.

[16] See footnote 15.

[17] See footnote 15.

[18] A trade rule is the means by which the FTC recommends action. The staff may recommend the drafting of a rule, additional work with other administrative agencies such as HEW, or make other recommendations to be considered by the Commissioners. If the FTC Commissioners decide that a rule is needed, they will initiate the process by printing the proposed rule and asking for comments. The whole process, if initiated, may take as long as 2 years before the final rule would go into effect.

The FTC rules would apply to all nursing homes, not only medicare and medicaid certified homes; the FTC act authorizes civil penalties up to $10,000 per violation.

FTC investigators interviewed consumers, regulators, and the nursing home industry around the country during 1978 in order to determine the extent of the problems faced by nursing home residents. In a speech before the Indiana Governor's Conference on Aging in October, FTC Commissioner Elizabeth Dole stated:

> . . . several disclosure rules for the $14 billion-a-year industry are under active consideration. These would include disclosure. in nursing home contracts. of refund and eviction policies and of services that aren't included in the basic fee.

Ms. Dole went on to describe the practices attributed to some nursing home providers:

> . . . Patients sometimes are charged for such items as aspirin, soap, bed bars, and crutches that are presumed to be included in the daily rate. . . . FTC staff's preliminary investigations have found instances which a nursing home was charging drug prices 24 percent higher than those of independent pharmacies. In other cases, patients have been evicted from homes when their private moneys are expended and the individual becomes financially eligible for medicaid. . . .[19]

The FTC plans to continue its investigations into nursing home practices during the next few months.

IV. QUALITY OF CARE: STUDIES AND ACTION

Consumer advocacy organizations, ombudsman, and State and private investigative efforts are developing methods to assure better care in long-term care facilities. Legislation at the State and Federal level is, more and more, calling for improvement in the care offered older Americans.

A. THE NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

The coalition is a group of 30 advocacy groups from around the country which are working at the local and State levels on nursing home reform issues. Additional groups are in the initial organizing stages from California to Maine.

Members of the coalition met in Washington in January and again in June of 1978 to set priorities, elect a board, and share information and skills with member organizations.

The coalition developed a paper, entitled "The Plight of the Nurses Aide in America's Nursing Homes: An Obstacle to Quality Care for Nursing Home Residents," which stated:

> Upgrading the working conditions of aides would directly benefit patients, for they depend almost entirely on the aides. Aides can only provide proper, tender care when their situation allows them to give each patient time and individual service. Aides need to understand patients' problems and to

---

[19] "An Investigation Into the Business of Caring for the Elderly," 1978 Indiana Governor's Conference on Aging, Oct. 24, 1978.

develop the skills to determine and provide appropriate remedies. Turnover of aides prohibits development of close, caring relationships. High turnover and the lack of training can result in treatment of the patient as an object rather than a person. In large part, the mental and physical well-being of patients depends on the ability of aides to care for them well.[20]

ACTION/VISTA gave the coalition a model grant in late 1978 to do local organizing throughout the country on improving patient care. The National Citizens' Coalition will receive 30 VISTA volunteers to work with member organizations in Oregon, Washington, Massachusetts, Tennessee, New York, North Carolina, Missouri, Wyoming, Minnesota, Wisconsin, Mississippi, Colorado, and Washington, D.C.

B. OMBUDSMAN DIRECTORS COALESCE

The State ombudsman directors throughout the country have formed an organization to foster communication among State advocates. The ombudsman programs are funded by the Administration on Aging through the State offices on aging to provide advocates for the institutionalized elderly. During a training session held in Washington, D.C., in January 1978, the ombudsman directors expressed the need for ongoing training and working relationships among the States. Many of the quality of care problems which each of the States might have with nursing homes has similar ramifications in the other States.

The reauthorization of the Older Americans' Act during 1978 gave the ombudsman statutory authority. Their responsibilities include the following:

(1) Investigate and resolve complaints made by or on behalf of older individuals who are residents of long-term care facilities relating to administrative action which may adversely affect the health, safety, welfare, and rights of such residents.

(2) Monitor the development and implementation of Federal, State, and local laws, regulations, and policies with respect to long-term care facilities in that State.

(3) Provide information as appropriate to public agencies regarding the problems of older individuals residing in long-term care facilities.

(4) Provide for training volunteers and promote the development of citizen organizations to participate in the ombudsman program.

(5) Carry out such other activities as the Commissioner deems appropriate.[21]

In addition to these five functions, States must develop: (1) Procedures for appropriate access by the ombudsman to long-term care facilities and to patients' records; (2) a statewide uniform reporting system to collect and analyze data relating to complaints and conditions; and (3) a procedure to assure that the ombudsman's files are kept confidential.

---

[20] "The Plight of Nurses Aide in America's Nursing Homes: An Obstacle to Quality Care for Nursing Home Residents," National Citizens Coalition for Nursing Home Reform, February 1978, p. 2. Papers are available from the Coalition at 2000 P Street NW., Washington, D.C. 20036.

[21] Comprehensive Older Americans Act Amendments of 1978, Public Law 95-478, section 307(a)(12)(A)(i)-(v).

C. Investigations

Virginia, Kentucky, Ohio, California, and New Jersey have released State investigative reports on the current problems in nursing homes. All of the studies found that poor patient care was a major problem and that care was not at all related to the amount homes were being paid.[22]

Virginia's Joint Legislative Audit and Review Commission makes the following suggestions:

> . . . limited number of nursing homes may be providing only marginally acceptable care. The State can initiate several actions to upgrade the quality of care provided in these homes. Foremost among these actions could be the development of intermediate sanctions to insure timely compliance with standards, and the establishment of a better system of processing patient complaints. Furthermore, medicaid reimbursement rates could be more closely linked to the quality of care to insure that a high level of quality is maintained.
>
> A need also exists for more specific State standards dealing with the qualifications and size of nursing home staff. The number of staff is the most important factor in explaining the high cost of some nursing home care. At the same time, however, too few or poorly trained staff can result in inadequate patient services. . . .[23]

Ohio found similar conditions:

> . . . we believe that our observation of poor care in many other homes shows that there is no guarantee that adequate quality of care is routinely and uniformly delivered to every nursing home resident in Ohio. Until such guarantee of adequate care exists, quality of life remains a phantom issue. The very fact of uneven care, excellent in some homes and terrible in others, is a sure sign of the nursing home program's failure.[24]

New Jersey reported that many of the items reimbursed by medicaid had nothing to do with direct patient care costs but were being billed for that purpose.[25]

D. Community Involvement

The State of Maryland's Nursing Home Advocate Office on Aging, the Urban Institute, and Citizens for Better Care Institute with the Michigan State Office on Aging have been examining the role of the community in assuring quality care.

The Maryland Nursing Home Advocate researched and then developed methods for encouraging nursing home residents to participate, assist, and to exercise their rights as patients and as citizens. Patients' councils, organized in several Maryland nursing homes, encourage patients to take an active role in daily decisions.[26]

---

[22] Cost-related reimbursement (see "Developments in Aging: 1977," pp. 91–92) does not require that costs be related to quality of care. A few States have included an element of directly relating quality care to the reimbursement formula. Although HEW is considering new regulations on cost-related reimbursement in 1979, they do not relate quality to costs.

[23] "Long-Term Care in Virginia," Joint Legislative Audit and Review Commission, Mar. 28, 1978, p. 70.

[24] "A Program in Crisis," the Ohio General Assembly Nursing Home Commission, June 1978, p. 7.

[25] New Jersey State Nursing Home Study Commission report on long-term care, "An Analysis of Medicaid Nursing Home Reimbursement: A Special Study," 1978, attached appendixes.

The Urban Institute developed information booklets intended to help consumers decide what homes provide the types of services and quality of care that their family or friends might need.[27]

The Kellogg Foundation funded a joint project by the Citizens for Better Care Institute and the Michigan Office on Aging project to develop a rating system for nursing homes. The rating system will take into account the deficiencies found by licensing inspectors and complaint information on the home. Findings will be available through computer terminals in local department of social services offices. The Michigan system is designed to help consumers understand the range of services available in the community.

E. LEGISLATION

Several States have introduced model legislation to deal with quality of care issues. Michigan has recently been successful in passing major nursing home reforms which drew much criticism from the provider industry. The law:

—Limits payments to homes that provide poor quality care.
—Requires safeguards for patients personal belongings.
—Requires a licensed nurse 24 hours per day.
—Allows the family of a terminally ill patient to stay in the nursing home with the patient.
—Guarantees access to families and consumer groups.
—Requires homes to report abuses to patients
—Forbids involuntary transfers of patients, while saying that when transfers do take place they must be planned.
—Allows receivers to be appointed when homes are providing poor care and requires the owner to pay penalties at the time the receiver is appointed.[28]

Two areas which have been of Federal concern which Michigan now deals with are: (1) A requirement that homes certified for either medicare or medicaid must be certified for both programs,[29] and (2) a specific prohibition on providers receiving kickbacks.[30]

Federal legislative efforts to address quality of care have been limited largely to reimbursement issues and enforcement of regulations. Alone, these reforms have not been totally effective.

Senator Frank Church proposed an amendment during the closing days of the 95th Congress. It would have required States that pay a profit to nursing homes as an incentive for efficiency to also provide quality care. However, no final action was taken on the amendment by the Senate. Senator Church is studying similar legislation for the 96th Congress.

---

[26] "How To Establish a Nursing Home Resident Council," Maryland Office on Aging.

[27] Urban Institute, 2100 M Street NW., Washington, D.C.

[28] Michigan Public Law 493.

[29] Medicaid/Medicare Reimbursement Reform Act as H.R. 5285 as amended by the Senate Finance Committee contained a provision that would have required the concurrent certification of nursing homes for medicaid and medicare. Senator Gaylord Nelson has asked HEW to study whether such a requirement would increase access to nursing homes.

[30] See "Developments in Aging: 1977". Kick-backs were prohibited by the medicare and meidcaid anti-fraud and abuse bill of 1977, Public Law 95–142.

V. FAMILY RESPONSIBILITY

Cost containment concern has triggered a widespread attempt by States to make families more responsible for a significant part of the expenses of relatives in nursing homes. One such method has been used during 1978, while another has been proposed. Massachusetts hopes to initiate a family responsibility clause for those with incomes over $23,000 a year. Other States have spouse responsibility, while some States have been using a prohibition of transfer of any major assets. "Spouse deeming" has, however, recently been ruled unconstitutional in California.

A. Massachusetts

Massachusetts has received a waiver from the U.S. Department of Health Education, and Welfare, to allow the assessment of charges to the families of nursing home patients. The State Department of Public Welfare has submitted a bill to the State legislature to set up a pilot program to test the family responsibility concept in the State's medicaid program. A similar bill was approved by a Joint Committee on Health Care, but was not considered in either of the two Houses of the legislature.

The family responsibility plan would have a progressive scale which would make children of nursing home patients with at least $23,000 income responsible for contributing $50 per month to their care. The range would be up to $300 per month for those families with incomes up to $50,000 a year. Families with higher incomes would pay for the entire nursing home care of their parents.

Massachusetts officials see the program as accomplishing additional purposes by giving families more of a role in caring for their parents. There is some indication that families might be encouraged to visit more and take a more active interest in what happens in the nursing home. The State hopes to strike a balance between family and government responsibility. In some cases, it is argued, families may be encouraged to keep their parents out of institutions and find services in the community.

Other States are considering similar types of assessment programs.

B. Prohibiting the Transfer of Assets

The U.S. Senate Finance Committee put forward a proposal during the 95th Congress that would have made ineligible for at least 1 year a person who had transferred a house or other significant asset for less than market value as a condition of becoming eligible for medicaid nursing home services.[31] The measure was reported and passed the Senate but no companion legislation existed in the House.

Many States have had prohibition on the transfer of assets as conditions for medicaid eligibility for some time. The length of time that a person would be ineligible varies by State. These usually involve the transfer of a house to a family member.

---

[31] Section [illegible]1 of H.R. 5285 as passed by the Senate Oct. 14, 1978. Resources of medicaid applicant to include certain assets previously disposed of for substantially less than market value.

C. Gray Panthers Win Suit on Spouse Deeming

States which have medicaid eligibility that differs from the Federal SSI standard have been using income from noninstitutionalized spouses as a contribution to pay for the spouse living in the nursing home. The Gray Panthers found that using income from one spouse without regard for the amount or duration of the contribution left the noninstitutionalized spouse without any income to pay for housing, food, fuel, or transportation.

On December 8, 1978, Federal District Judge Ritchie ruled in the District of Columbia that States could not continue to use spouse income without regard to the needs of the noninstitutionalized spouse. The Gray Panthers do not want to say that spouses do not have some responsibility, rather the needs of the person outside the home must be considered.

Other States use spouse income, but after 6 months the noninstitutionalized spouse is not required to contribute.

Judge Ritchie ordered that HEW demand States to pass laws, propose and publish regulations before they determine what is "actually available" income to help pay for the institutionalized spouse.[32]

---

[32] *Gray Panthers v. Secretary, Department of Health, Education, and Welfare*, U.S. District Court, District of Columbia, Civ. No. 78-0061, Dec. 8, 1978. See Commerce Clearing House Medicare-Medicaid Guide No. 29426.

CHAPTER VI

MEDI-GAP, OTHER CONSUMER ISSUES

Medi-gap, a popular term describing private health insurance sold to supplement medicare's essential but uneven coverage, became a major consumer issue in 1978.

Hearings[1] before this committee exposed unscrupulous sales practices which feed upon confusion and fears related to medicare.

Testimony and related studies, coupled with growing concern by the Federal Trade Commission and other agencies, led to the beginnings of a joint action by the end of the year.

Additional action on consumer issues of importance to older Americans occurred as:

—A bill to encourage establishment of consumer cooperatives became law.

—Automated electronic banking transactions, including direct deposit of social security checks, became the subject of a law offering new safeguards.

—The Federal Trade Commission continued to advance trade regulation rules intended to eliminate abuses in hearing aid sales and funeral industry practices.

I. HIGH PRESSURE MEDI-GAP SALES DRAW FIRE

The specter of rising health care costs and constant fear of an illness which will deplete all assets is a way of life for many older Americans.[2] Medicare has been a great help, but most find ways to fill in the gaps in medicare payments (which now pay for about 40 percent of the total health care bill for older Americans). A number of private health insurance companies have responded by marketing medicare supplemental, or medi-gap, insurance policies. There are vast differences among the policies offered—in benefits, in price, and in the ways they are sold.

As Wisconsin State Insurance Commissioner Harold R. Wilde told the committee: "Millions make a good choice. Millions of others do not."[3]

---

[1] "Medi-Gap: Private Health Insurance Supplements to Medicare," part 1, Washington, D.C., May 16, 1978; part 2, Washington, D.C., June 29, 1978. Hearings before the Special Committee on Aging, U.S. Senate.

[2] See chapter III, p. 42 for discussion of most recent statistics on health expenditures for the elderly.

[3] The following discussion of the sale of medicare supplemental insurance to the elderly, based on committee hearings in May and June 1978, focuses attention on specific sales abuses which have been detected in a number of States, primarily involving high-pressure sales techniques employed by some insurance agents to sell policies to the elderly. Not all insurance agents operate unethically. The widespread incidences of oversale and abuse, however, clearly offer reasons for concern.

Additional testimony before both the Senate and House Committees on Aging challenged the value of health insurance policies marketed by some insurance companies. That private health insurance to supplement medicare is a valuable purchase for many older Americans

(Continued)

Two-thirds of the Nation's population age 65 and over have purchased some form of private health insurance to supplement medicare's payments for hospital charges. Over one-half purchased some form of private health insurance to supplement medicare's payments for physicians and other medical services.[4]

At least $1 billion is spent each year by older Americans for premiums for private health insurance policies to supplement medicare coverage.[5] Policies are purchased by older Americans at all income levels, including the lowest. There is increasing evidence that many older Americans who participate in State medicaid programs—and therefore may receive services not covered under medicare—nevertheless purchase supplemental health insurance policies from a number of companies.[6]

The largest single seller of medicare supplemental health insurance are the Nation's Blue Cross and Blue Shield plans. Blue Cross and Blue Shield supplemental hospital policies are held by half (51.7 percent) of those over the age of 65 with any form of supplemental coverage. Private insurance companies sell insurance to 43.4 percent of the medicare-eligible population.[7]

All the plans offered to older consumers by Blue Cross and Blue Shield are different, and there is even more variation among the many forms of medi-gap insurance marketed by private insurance companies.[8] Plans vary widely; some mesh better with medicare benefits than others; the costs range markedly, and it is difficult to make comparisons from one policy to another.

Medi-gap insurance is usually sold through company agents, door-to-door in the home, or through direct mail advertising.

Nationwide, private health insurance pays for about 5 percent of all health expenditures of the elderly.[9]

(Continued)
is not in dispute. Many companies offer good protection at reasonable cost. The testimony, however, and scrutiny by some States of the ratio between premiums paid and benefits paid on certain policies, make it clear that this is not always the case. For example, medicare supplemental plans offered by Blue Cross and Blue Shield throughout the country traditionally pay between 80 cents and 90 cents in benefits for every $1 in premiums collected. In contrast, the State of California recently revoked the license of the Cosmopolitan Life Insurance Co. to sell health insurance policies to California's elderly after the department of insurance found that the company was paying less than 50 cents in benefits on every premium dollar it collected for the policies. (Source: News release, California Department of Insurance, Nov. 10, 1978.) Wisconsin Insurance Commissioner Harold R. Wilde, in testimony before the committee in May, said that an audit of policies filed with his office revealed some with a 10 percent loss ratio—or policies which were paying 10 cents in benefits for every $1 collected in premiums.

[4] Estimates of the Social Security Administration, contained in "Private Health Insurance Plans 1976: An Evaluation," Social Security Bulletin, September 1978. See chart on p. 90.

[5] An earlier committee report estimated that, at a minimum, over half a billion dollars on premiums for private health insurance policies were spent by older Americans each year. See "Private Health Insurance Supplementary to Medicare," working paper, U.S. Senate Special Committee on Aging, December 1974.

There were not then, nor are there now, official industry estimates of this amount. The 1974 estimate was based on the average monthly charge by Blue Cross-Blue Shield low-cost option plans as of April 1974. Increases in premiums, number of elderly purchasing private health insurance, and variety of higher cost private plans available since that time make the earlier estimate no longer applicable.

[6] Testimony taken from Wisconsin State Insurance Commissioner Harold R. Wilde estimated that 20 percent of Wisconsin's medicaid population hold some form of private health insurance. Hearings cited in footnote 1, part 1. A survey conducted by the GAO suggests that somewhat over 10 percent of elderly medicaid recipients hold some form of private health insurance. See p. 101, following, for description of the survey and results.

[7] Report cited in footnote 4.

[8] No reliable statistics or estimates exist on the number of companies which sell this type of health insurance.

[9] Report cited in footnote 4.

A. Common Benefits and Types of Medi-Gap Insurance

Most medi-gap policies sold to older Americans are designed to supplement benefits for medicare-covered services, paying for some, or all, of medicare's deductibles and coinsurance charges for covered medical and hospital services. Few supplemental policies are designed to provide benefits for medical services which are not covered by medicare, such as out-of-hospital prescription drugs, most nursing home care, and dental or eye care. Many older Americans, however, do not realize that insurance sold with a claim to "cover all of medicare's gaps" rarely includes the largest gaps—those medical services for which medicare pays nothing.

As the following chart shows, there is less private coverage available for essential services not included under medicare than for deductibles and coinsurance charges. For example, only 3.3 percent of the over-65 population have private insurance coverage for dental services, which is also excluded from medicare benefits. About 21 percent have some form of coverage for nursing home services, primarily to extend medicare's daily reimbursement rates for skilled nursing services in medicare-certified nursing homes only. There is little, or no, coverage for custodial nursing home services available either through medicare or any private supplemental insurance.

TYPES OF PRIVATE HEALTH INSURANCE COVERAGE AGE 65 AND OVER[1]

Type of service covered	Number (thousands)	Percent
Hospital care	14,592	62.8
Physician's services:		
Surgical services	12,917	55.6
In-hospital visits	10,078	43.4
X-ray and laboratory examinations	7,955	34.2
Office and home visits	5,602	24.1
Dental care	770	3.3
Prescribed drugs (out of hospital)	4,782	20.6
Private-duty nursing	4,643	20.0
Visiting nurse service	5,022	21.6
Nursing home care	4,862	20.9

[1] Social Security Administration estimate as of Dec. 31, 1976. Adapted from report cited in footnote 4. The Health Insurance Association of America estimates that 55.6 percent of the population age 65 and over hold private insurance policies for hospital services, and 45.7 percent hold private insurance policies for surgical services.

There are three major types of medi-gap policies most frequently sold to older Americans. Not all are specifically designed to fill in medicare's gaps.

Medicare supplemental policies.—Sometimes referred to as "wrap-around" policies, medicare supplemental policies are commonly offered by health, accident, and life insurance companies to medicare beneficiaries as protection against health care costs not covered by medicare. The most common policies are designed to pay the deductibles and coinsurance charges required by medicare.[10]

---

[10] Medicare (part A) hospital insurance carries a deductible of $160, beginning in January 1979, for each hospital benefit period which the beneficiary is responsible for paying. This amount, by law, increases each year with increases in the Consumer Price Index for hospital services. Since 1966, when medicare took effect, there has been a four-fold increase in this amount, from $40 to $160. After the deductible, part A pays for all hospital costs for the first 60 days of hospitalization. From the 61st through the 90th day, the beneficiary is responsible for $40 per day. During a one-time "lifetime reserve" period of an additional 60 days of hospitalization coverage, the patient is responsible for $80 per day.

Medicare (part B) medical insurance requires the beneficiary to pay a medical insurance deductible of $60 in "reasonable charges" for medical services received each calendar year. In addition, the beneficiary is responsible for payment of 20 percent of the "reasonable charges" for all medical services received, after the initial deductible has been met.

See chapter III, p. 42 of this report for further discussion of medicare payments and the total out-of-pocket medical expenses which beneficiaries must pay themselves.

Some offer supplements to medicare part A—hospitalization benefits—only, paying for the initial deductible of $160 per benefit period. Some add benefits for prolonged hospital stays, paying a specified daily rate for hospitalization after medicare benefits run out. Some also cover some of the gaps left by medicare's part B benefits—medical services.[11]

More specialized types of medicare supplemental policies offered by many insurers are nursing home policies. Nursing home policies most often pay a limited daily rate for services received in a skilled nursing facility, beginning after the bulk of medicare's skilled nursing payments have been used up. Virtually no private policies offer benefits for custodial nursing home services or for care received in other than medicare-certified skilled nursing facilities.[12]

Hospital indemnity policies.—Indemnity policies typically pay a specified dollar per day amount for periods of hospitalization. The daily benefits vary widely—anywhere from $10 a day to $60 a day. Some will pay in addition to medicare benefits, while others will pay only after medicare hospitalization benefits have run out.[13] Indemnity policies are often sold by advertising geared to an "extra cash on hand" promotion, as many will make benefit payments regardless of other insurance policies held by the purchaser. Hospital indemnity policies are available to consumers of all ages, but they are marketed heavily to the over-65 population.

Limited benefit and "dread disease" policies.—A number of insurance companies offer policies which will pay benefits only for one particular problem. The most common example is a "cancer policy," which is designed to pay benefits only if the purchaser contracts cancer, sometimes particular kinds of cancer. Many policies are also designed to pay benefits only for certain kinds of treatment for cancer and contain other limitations and exclusions. Even though such limited-benefit policies are often aggressively marketed to the over-65 population, they are usually designed for all age groups and therefore overlap medicare benefits, as well as other health insurance policies.

An analysis of the availability of medi-gap policies by staff of the Urban Institute has produced the following characterization of available policy benefits:[14]

---

[11] See footnote 10.

[12] After certain conditions have been met, medicare's part A hospital insurance will pay all the costs of care received in a medicare-certified skilled nursing facility for up to 20 days of care. From the 21st to 100th day, the beneficiary is responsible for $13 a day. Medicare pays for about 1 percent of the total costs of nursing home care in the country. Most private nursing home policies require that the same conditions be met.

[13] See footnote 10.

[14] "Medical Expenditures Among the Elderly: The Impact of Medicare Gaps," working paper, Urban Institute, Washington, D.C., revised March 1978. This analysis is reinforced by a summary of the 103 medicare supplement plans offered throughout the country by Blue Cross and Blue Shield Associations. All of these plans, with the exception of a few with special riders, pay the initial deductible for medicare part A hospital insurance. A few offer a somewhat lower dollar amount. All pay the deductible from the 61st to 90th day of hospital confinement. Most pay the daily deductible during the 60-day lifetime reserve period. About half (54) provide some coverage for hospital days beyond the medicare limit. There are usually ceilings on the number of days for the extension or the maximum benefit which can be paid, with the most common limitation on number of days, usually 30 days. A few plans, classified as major medical plans, provide coverage for more extensive hospital stays.

About 60 percent will pay medicare's daily deductible for skilled nursing care from the 21st to 100th day. About 80 percent will pay the yearly $60 deductible and 20 percent coinsurance charge for medicare's part B medical insurance. About 15 percent, however, will meet the 20 percent coinsurance charge only, not providing coverage for the initial $60 per year deductible.

Source: "Medicare Complementary Coverage Revisions—Summary of Plan Programs for the Other-Than-Group Market," Blue Cross/Blue Shield, Subscriber Relations Bulletin No. 51, April 24, 1978.

- —Private hospital insurance sold to medicare beneficiaries covers medicare part A deductibles more frequently than stays beyond medicare limits.
- —Medical insurance covers coinsurance, or open-ended expenditures, more frequently than deductibles, but may cover charges in excess of medicare's reasonable charge.
- —Nursing home coverage more frequently covers medicare cost-sharing than additional levels of care.
- —Major medical coverage is of limited availability.
- —Most benefits have ceilings.

B. THE COMMITTEE'S HEARINGS: PROBLEMS IN THE MARKETPLACE

Testimony presented to the Committee on Aging in May and June 1978 revealed widespread misinformation regarding medi-gap insurance and marketing abuses of elderly consumers.[15]

Members of the committee summarized reports received by the committee which led to the hearings:

> A number of questions have been raised about such insurance, including suggestions that many older Americans purchase policies of questionable value, multiple policies well in excess of probable need, and policies offering benefits inappropriate to need. The committee wants to know how pervasive these problems are and what factors may contribute to unnecessary expenditures of precious retirement income.[16]
>
> Adequate health insurance is a protection everyone needs, particularly in these days of ever-increasing hospital costs. The elderly, however, are most concerned about insurance coverage as they fear the prospect of a catastrophic illness or prolonged ill health, either of which may deplete their life savings. As a result, the elderly have become a new and expanding market, as well as an easy mark, so to speak, for insurance salesmen who sell expensive policies to the elderly, assuring them that the insurance will pay for what medicare does not cover. Unfortunately, this is not always the case.[17]

CASE EXAMPLES

The following case examples emerged during the committee hearings:

Wisconsin.—An 87-year-old woman was sold 19 health insurance policies from 9 different companies by 6 different agents in just over 1 year. She was committed to payments of almost $4,000 a year in insurance premiums. Most of the policies were overlapping and duplicative of each other.[18]

A social service worker found that 103 of 191 elderly she counseled had insurance problems. All 103 needed information and counseling on how to use their medicare and private health insurance policies. Twenty-four had purchased too much health insurance, holding overlapping and duplicate policies.[19]

---

[15] Hearings cited in footnote 1.

[16] Opening statement of Senator Lawton Chiles, hearings cited in footnote 1, pt. 1, p. 1.

[17] Opening statement of Senator Pete Domenici, hearing cited in footnote 1, pt. 1, p. 27.

[18] Letter to Senator Lawton Chiles, hearings cited in footnote 1, pt. 1, p. 3.

[19] Statement of Mary M. Bach, staff attorney, Center for Public Representation, Madison, Wis. Hearings cited in footnote 1, pt. 1, p. 162.

Ohio.—An elderly couple were told by an insurance agent at their door that the medicare program would "run out" in 1979 and that they needed more health insurance. The couple gave him a check for $787.80 before they found out that the agent's statement was not accurate.[20]

A 76-year-old woman was sold 13 health and life insurance policies by 5 different agents from the same insurance company during one 5-month period. Two of the life policies had forged signatures. An additional three policies, originally sold to her by the same agents, were refunded when the company's computer detected duplicate sales. The woman was committed to annual premium payments of $9,158.61 to Bankers Life & Casualty Co. of Illinois—68 percent of her total annual income.[21]

California.—A 77-year-old man was sold a life insurance policy by an insurance agent who claimed that the product he was selling was an investment in a savings and loan association, planning to build an establishment in San Diego soon. After 2 years, and two payments of $1,176 each, when the business had not materialized, the man sought advice and was informed that he had purchased a life insurance policy.[22]

New Mexico.—An elderly New Mexico resident purchased over 30 insurance policies during a 2-year period. Total premiums of $3,843.18 were paid to nine companies. Another elderly New Mexican purchased 16 insurance policies during a period of 2 years.[23]

A New Mexico insurance agent who said he was collecting medicare premiums sold health insurance policies to 157 elderly. He told them he was soliciting funds to maintain the medicare program until Congress could appropriate more funds.[24]

Florida.—An elderly couple paid $2,882 to one insurance company for 19 separate health insurance policies in a period of slightly more than 1 year. Their situation was discovered by visiting children when the couple complained that they did not have enough money to keep their stove, refrigerator, and television set working.[25]

An 88-year-old woman, with an income of less than $5,000 a year, was sold more than $10,400 in health insurance in a 1-year period.[26]

Texas.—A Texas district attorney investigated and prosecuted a group of insurance agents who had obtained $200,000 from elderly Texans claiming sales of "paid-up" hospitalization insurance. No such insurance existed, and no policies were delivered. When pressed, salesmen delivered deeds for worthless lots of land, some of which were deeded to more than one victim.[27]

A number of elderly women were also solicited for accident and health insurance policies, but received instead worthless vehicle repair warranties. One victim, age 92, was solicited for insurance 13 times between April 1972 and July 1974, and paid $4,440 for insurance policies she never received. An 83-year-old woman paid insurance agents

---

[20] Letter to Senator John Glenn, hearings cited in footnote 1, pt. 1, p. 29.

[21] Testimony of Robert E. Lowry, hearings cited in footnote 1, pt. 1, pp. 30–46.

[22] Testimony of Jules Klowden, hearings cited in footnote 1, pt. 1, p. 47.

[23] Testimony of Manuel A. Garcia, Jr., Department of Insurance, Santa Fe, N. Mex. Hearings cited in footnote 1, pt. 2, p. 263.

[24] Testimony cited in footnote 23.

[25] Testimony of W. W. Cooper, Office of Florida Insurance Commissioner. Hearings cited in footnote 1, pt. 1, p. 87.

[26] Letter to Senator Lawton Chiles, hearings cited in footnote 1, pt. 2, p. 212.

[27] Testimony of C. L. Woodard, U.S. Postal Inspector, Houston, Tex., and Wiley Cheatham, district attorney, Cuero, Tex. Hearings cited in footnote 1, pt. 2, pp. 214–234.

$11,035 for health and accident and life insurance policies. She received no insurance. She did not own a car, but she was eventually provided with a vehicle-repair warranty contract.[28]

WIDE ROOM FOR AGENT ABUSES

Most medi-gap insurance is sold either through the mail on a direct-response advertising basis, or door-to-door by individual insurance agents.

Witnesses appearing before the committee made it clear that many insurance agents were eager to make high commissions by taking advantage of fears of rising health costs. Common tactics used by agents were misrepresentations of policy benefits, piling policy on top of policy, and switching policies from one company to another.

Mr. C. L. Woodard, U.S. Postal Inspector, Houston, Tex., presented the committee with a list of 14 separate tactics examined in Texas investigations:[29]

> One: The seeking out of elderly people who are known to be susceptible to repeated insurance sales.
>
> Two: The use of "goose lists" in identifying and locating aged victims, and in disseminating information from one agent or ex-agent to another on the pitch or technique to be used.
>
> Three: Salesmen claiming to be there to collect on accident and health premiums due on existing policies while actually soliciting new business.
>
> Four: Salesmen claiming to represent the victim's accident and health companies.
>
> Five: Salesmen claiming to be combining their insurance and sometimes getting money back.
>
> Six: Unlicensed agents soliciting insurance sales to be "fronted" by licensed agents.
>
> Seven: Licensed and unlicensed agents claiming to represent companies that were familiar to the aged victims, such as American Insurance Co.—anything with "American" in it is good to use on an old person—and tricking them into signing new applications for insurance with other companies.
>
> Eight: Salesmen representing that "Our company has bought out your company" and that "The company has sent us out here to collect for your insurance and get these new papers signed," while actually soliciting new hospitalization business.
>
> Nine: Salesmen's representations such as "No waiting periods." "This policy will pay everything" or "Everything that medicare does not pay," "This is a paid-up hospitalization policy," and "You will start getting so many dollars per month back on this paid-up policy."
>
> Ten: Salesmen represented that they would reinstate expired accident and health policies which in some cases had been expired for 2 or 3 years and had been issued by companies they did not represent.

---

[28] Testimony cited in footnote 27, p. 220.
[29] Testimony cited in footnote 27, pp. 218–219.

126

Eleven: Some solicitations were as simple as "Get your checkbook; your insurance is due."

Twelve: Salesmen claiming that they were there to help the aged victims with their social security while actually soliciting accident and health business.

Thirteen: The use of familiar sounding and appealing agency trade styles such as the American Agency, Senior Citizens Agency, and First Continental Agency—these names were actually used in Texas—to induce aged people to listen to the sales pitches.

Fourteen: Falsification of applications for new accident and health policies by clean sheeting—omitting unfavorable information such as age, health conditions, and additional policies in force; forging signatures of applicants; and fence-post policies—completing applications in the name of relatives or others, unknown to the victims. This is done to bypass underwriting rules when it is known the victims already have the maximum coverage in effect with a company.

A State insurance commissioner noted that such tactics were prevalent in his State. He said:

> Agents tell us about lists of "mooches," or "cripples," or "marks" that have been circulated among the medi-scare peddlers. . . . We are aware of teams of agents switching from one company to another company and, in the process, thousands of people getting caught in a war as policies are switched from one company to another company. . . . We go into a company's files and we find dozens of medical applications from particular agents which have been "clean sheeted" . . . then when they find that the person had a medical history, they retract the claim and refund the premium. . . . It is a process quite frequently engaged in unannounced to the purchaser. . . . We come across evidence of systematic forgery and routine postdating of applications.[30]

Additional tactics reported to the committee include tearing out insurance policy riders which limit benefits before policy delivery; writing policies under a variety of names to avoid detection of multiple sales to the same person; forging names on applications; and writing health and life policies on relatives, without the relative's knowledge. Agents also frequently postdate applications for insurance policies, which in effect lengthens waiting periods for effective coverage, lessening the chances of payments. Purchasers are often under the impression, however, that the policy is effective as of the date the first premium check is cashed. Many agents also find it easy to "roll over" policies—coming back again and again to replace old policies with new ones, receiving a new, higher commission each time, but leaving the consumer with no more protection, higher premiums, and a brandnew waiting period for effective date of coverage.[31]

---

[30] Testimony of Harold Wilde, commissioner of insurance, State of Wisconsin. Hearings cited in footnote 1, part 1, pp. 77–78.

[31] See testimony of Lowry, Klowden, Grubbs, Wilde, and Cooper, hearings cited in footnote 1, part 1. See testimony of Woodard, Cheatham, Dole, Mike, and Garcia, hearings cited in footnote 1, part 2.

DIFFICULTIES IN ABUSE DETECTION

After hearing witness testimony, Senator John Glenn commented:

> Too often, there is no control exercised by the companies involved. How can we correct this? How can we get these people recompensed for their expenses and the excess policies they have already bought? More importantly, how can we control this better in the future, through whatever Government action, if that is required, or through action by the insurance companies and State insurance commissions controlling what has gotten to be a real flimflam, a real fraud situation?[32]

Many witnesses pointed to the difficulties faced by State insurance commissioners and State and local prosecutors in monitoring the actions of individual insurance agents.

First, many older Americans are simply not aware of the fact that they are being victimized.[33]

When insurance commissioners receive information which leads them to believe that an agent, or ring of agents, is systematically bilking the elderly in their State, they first have to explain to victims what is wrong with the insurance they have and how they are being victimized.[34]

Even then, most commissioners cannot act without a formal complaint. Victims are often too embarrassed to either admit that they have been victimized, or participate in court proceedings against the agent.[35]

State insurance commissioners and others asked whether insurance companies do enough to monitor and control the actions of their own agents.

Witnesses testified that:

—Multiple sales are encouraged by policies which are designed to provide limited, incomplete coverage.[36]

—High "front-end" commission structures provide incentives for agents to continually exchange old policies for new. Some companies allow a very high commission on new, first-year policies with decreasing commission percentages on policy renewals, or pay higher percentages for shorter term policies.[37]

—Lax screening of agents employed to sell policies and insufficient review of agent performance may encourage agent abuse of consumers. Some companies do not accept responsibility for the actions of their selling agents, contracting for their services rather than treating them as company employees. Charges were also made that unofficial company policies encourage agents not to worry about the company's written policies, or State regulations, as long as their sales volume stays high.[38]

---

[32] Senator John Glenn, hearings cited in footnote 1, part 1, p. 29.

[33] Testimony of Joseph C. Mike, insurance commissioner, State of Connecticut, and chairman, National Association of Insurance Commissioners Accident and Health Subcommittee. Hearings cited in footnote 1, part 2, p. 251.

[34] Testimony of Joseph C. Mike, cited in footnote 33, p. 251. Testimony of Harold R. Wilde, cited in footnote 30, p. 76.

[35] Testimony of Joseph C. Mike, cited in footnote 33. Testimony of Harold R. Wilde, cited in footnote 30. Testimony of Manuel A. Garcia, cited in footnote 23. See also testimony of Dole, Woodard, and Cheatham, hearings cited in footnote 1, part 2.

[36] Testimony of Elizabeth Hanford Dole, Federal Trade Commission, at hearings cited in footnote 1, part 2, pp. 234–245. Also see testimony of Jules Klowden, cited in footnote 22 and testimony of Harold R. Wilde, cited in footnote 30.

[37] Testimony of Harold R. Wilde, cited in footnote 30. Testimony of Elizabeth Hanford Dole, cited in footnote 36. See also testimony of Russell Van Kampen, marketing vice president, Bankers Life & Casualty Co., Chicago, Ill. Hearings cited in footnote 1, part 1, p. 69.

LACK OF INFORMATION

Widespread confusion on the part of medicare beneficiaries regarding what is covered under medicare, and therefore does not require additional insurance is compounded by a paucity of useful information.

According to Federal Trade Commissioner Elizabeth Dole:[39]

> . . . there is such a dearth of consumer information in the medicare supplemental market that it is almost impossible for consumers to make rational purchase decisions. Agent misconduct is thus facilitated. A great variety of differing policies effectively precludes buyers from comparing benefits or premiums, resulting in lack of price competition and the sale of duplicate coverage to hundreds of thousands of people who are under the impression that they are filling all gaps in medicare. Other areas of widespread misunderstanding are the limited nature of medicare supplement coverage, the relatively high cost of coverage for the initial deductibles compared to insurance against catastrophic medical expenses, and exclusions of preexisting medical conditions.

Joseph C. Mike, commissioner of insurance, State of Connecticut, and chairman of the National Association of Insurance Commissioner's Subcommittee on Health and Accident Insurance, told the committee that State insurance commissioners had "serious doubts" that the public fully understood the functions of medicare, and the value or the benefits of the private health insurance they bought.[40]

The same point was made by Wisconsin State Insurance Commissioner Harold R. Wilde:

> When you're dealing with a subject which causes you and your peers continuous and daily worry, when the terms of medicare and health insurance coverage in general are extremely confusing and nonstandardized, and when you've been identified as a target group by a class of hard-selling predator-agents and companies, it is difficult to be either smart or lucky.[41]

An FTC staff report submitted to this committee in July speculated on the consequences of limited information or misinformation about medi-gap insurance policies:[42]

---

[38] Testimony of Harold R. Wilde, cited in footnote 30. Testimony of Manuel A. Garcia, cited in footnote 23. Testimony of C. L. Woodard and Wiley Cheatham, cited in footnote 27. See also testimony of representatives of Bankers Life & Casualty Co., Chicago, Ill., hearings cited in footnote 1, part 1, pp. 53–75.

[39] Testimony of Elizabeth Hanford Dole, cited in footnote 36, p. 235.

[40] Testimony of Joseph C. Mike, cited in footnote 33, p. 247. See also testimony of Jules Klowden, cited in footnote 22, p. 48.

[41] Testimony of Harold R. Wilde, cited in footnote 30, p. 82.

[42] "Policy Planning Issues Paper: Private Health Insurance to Supplement Medicare," staff report. Federal Trade Commission, submitted to the Committee on Aging in July 1978. See hearings cited in footnote 1, part 2, pp. 275–318. See specifically pp. 286–289.

No price competition.—The lack of standardization and complexity of available coverage make comparison shopping and price competition almost impossible. An example was offered of two supplemental policies offered to Wisconsin's elderly. One policy providing what was described as fairly comprehensive coverage was available for $95 a year. Another, offering much more restrictive benefits, was available for between $200 and $236 a year, depending on age.

Duplicate coverage.—Consumers often buy two or more policies to obtain "complete" coverage. But policies generally contain coordination of benefits clauses, precluding more than one payment in areas of overlap.

Coverage not equal to expectations.—Many older Americans think they have much more extensive coverage than they actually do. Advertisements and agents suggest that a policy will cover everything medicare doesn't. Since advertising and agent solicitations are usually the only source of information on the insurance in question (other than the difficult-to-read policy form), it is difficult to determine the validity of the claim.

Inability to challenge claims handling.—Medi-gap insurers have little incentive to be responsible to their policyholders, as elderly are often reluctant to cancel health insurance policies even if they are dissatisfied. They are often afraid they will not be able to obtain other health insurance protection because of advanced age and existing health problems. The report cites examples of high rates of claim denials by one medi-gap insurer and points out that insurance commissioners and others receive many complaints from elderly insurance policy holders.

C. ADDITIONAL EVIDENCE OF ABUSES

The House Select Committee on Aging conducted similar hearings in December 1978, which further reinforced the evidence of widespread abuses in the sale of medi-gap insurance to older Americans.[43]

NEWSPAPER INVESTIGATIONS

Independent investigations conducted in Illinois, New Jersey, and Tennessee also uncovered medi-gap abuses.

A team of investigative reporters for the Chicago Tribune made an undercover investigation of insurance sales to the elderly and documented similar cases in rural Tennessee, Illinois, and Georgia.[44]

An investigative reporter examined the sale of medi-gap insurance to the elderly in New Jersey. In a series of articles published in the Newark Star-Ledger during February and March, reporter Herb Jaffe charged that more than $500 million a year was being spent in the State by consumers of all ages for health insurance policies which were not regulated or approved by the New Jersey State Insurance Commission, including "useless" health insurance policies. He also found widespread use of medicare "scare" tactics to sell policies to the elderly.[45]

---

[43] "Abuses In the Sale of Health Insurance to the Elderly," hearing, House Select Committee on Aging, Nov. 28, 1978. Hearing not in print at time of publication of this report.

[44] Chicago Tribune, "Insurance Firms That Feast on Fears of the Aged," Sept. 29, 1978, p. 1.

[45] Newark Star-Ledger, series of articles by Herb Jaffee, January through March 1978. Also see hearings cited in footnote 1, part 1, pp. 5–20.

Legal Services of Nashville and Middle Tennessee, Inc., conducted an investigation of the sale of low-premium "industrial" life insurance and medi-gap insurance to Nashville residents early in 1978. Their report charged that the elderly were the most vulnerable to oversale of inferior insurance policies and that the State department of insurance was not doing enough to protect low-income elderly and others from abusive insurance practices.[46] Similar charges were made by a separate investigation conducted by a team of reporters for the Nashville Tennessean.[47]

D. Actions Taken Since Committee Hearings

Groups representing State insurance commissioners and the health insurance industry have taken action to investigate reported abuses and propose changes in the way health insurance policies are sold to the elderly. In addition, the Federal Trade Commission has begun an evaluation of the relative effectiveness of State insurance regulation of medi-gap policy sales. The Department of Health, Education, and Welfare is making a number of changes in the way information is provided to medicare beneficiaries.

NEW STANDARDS TO BE PROPOSED BY NAIC

In June, the National Association of Insurance Commissioners created a special task force "to examine the need for, and draft in accordance with perceived needs, rules governing the sale of medicare supplement health insurance." [48]

The task force met in October and drafted a position statement on medi-gap insurance, acknowledging that "serious marketing abuses occur in the sale of health insurance to the elderly, both in the area of agent's sales tactics and company advertising and solicitation practices." [49]

The task force agenda includes development of model State legislation and regulations governing minimum standards and information disclosure requirements for medi-gap insurance as well as standards for conversion of employee group health insurance to medicare supplemental coverage upon retirement. The task force will also make recommendations to State insurance commissioners and insurance companies on ways to improve control of agent practices and insurer marketing abuses. [50]

The NAIC adopted the task force's position paper and proposed model legislation to set minimum standards and information disclosure for medicare supplemental policies in December. Work is continuing on model regulations and a consumer buyer's guide, and final action is expected by the NAIC during 1979.

---

[46] Report, "Poor People and the Insurance Industry in Tennessee," prepared by staff attorneys, Legal Services of Nashville and Middle Tennessee, Inc., Nashville, Tenn., 1978.

[47] The Nashville Tennessean, series of articles by Carolyn Shoulders and Linda Solomon, August and September 1978.

[48] Testimony of Joseph C. Mike, cited in footnote 33, p. 246.

[49] "Position Paper for the Task Force on Medicare Supplement and Limited Health Insurance," Task Force on Medicare Supplement and Limited Health Insurance, National Association of Insurance Commissioners. The position paper was later adopted by the NAIC. "Proceedings of the National Association of Insurance Commissioners," semiannual meeting, Las Vegas, Nev., Dec. 3–8, 1978.

[50] Documents cited in footnote 49.

NAIC-proposed legislation and regulations governing the sale of medi-gap insurance will be advisory only. Final action must be taken by each individual State legislature and State insurance commission.

THE FTC STUDY

Federal Trade Commissioner Dole discussed the different directions being taken by State insurance commissions to regulate medi-gap sales.[51] Noting that State actions to date had taken three major policy approaches,[52] she proposed an evaluation of existing State regulation of medi-gap insurance with central focus on the effectiveness of different regulatory approaches. The evaluation, she said, should be a joint effort by the Department of Health, Education, and Welfare, the National Association of Insurance Commissioners, and the Federal Trade Commission.

Members of the Committee on Aging urged all three groups to participate in such an effort,[53] and the committee was notified by the FTC in November that the study would be undertaken.[54]

INDUSTRY RESPONSE

Representatives of the health insurance industry have acknowledged the problem. Addressing members of the Health Insurance Association of America (HIAA), Mr. Robert Beck, chairman of the association and president of the Prudential Insurance Co. of America, said that "the few companies" selling medi-gap policies to the elderly gave a bad name to the whole industry. Mr. Beck also suggested that many medi-gap policies have a ratio of benefits to premiums far too low to ever be expected to provide a reasonable return, and he charged the association to recognize certain industry shortcomings and face up to its responsibilities in correcting them.[55]

Shortly after the committee hearings, HIAA created its own medicare supplement task force to make recommendations to insurance companies for changes in marketing medi-gap insurance.

The HIAA task force is surveying about 320 member companies to determine the total sales volume in medi-gap insurance for the elderly, develop a profile of the kinds of policies being sold, and determine company policies and procedures for agent training and detection of duplicative and overlapping policies sold to consumers.[56]

---

[51] Hearings cited in footnote 1, part 2, pp. 234–245.

[52] Dole testimony, cited in footnote 51, pp. 238–240. (1) Minimum standards: Commissioner Dole pointed out that California had established a minimum loss ratio of 55 percent for medicare supplemental policies. An Illinois statute requires that all policies delivered in the State must fill certain gaps, including the initial part A deductible, part A copayments, and part B coinsurance. (2) Establishing categories of medicare supplemental insurance and requiring that each policy sold in a State carry an appropriate label as a way to bring about standardization: Wisconsin has pursued this alternative, establishing four benefit levels for medi-gap policies. California has established three categories for medicare supplements. (3) Efforts to provide information to consumers to permit the market to perform more effectively: Policy disclosure is the most common, and different disclosure policies are now in effect in Wisconsin, California, Oregon, and New Mexico.

[53] Letters to Joseph Califano, Secretary, Department of Health, Education, and Welfare; Michael Pertschuck, Director, Federal Trade Commission; and Harold B. McGuffey, chairman, National Association of Insurance Commissioners; from Senators Frank Church, Lawton Chiles, John Glenn, and Pete Domenici, July 18, 1978.

[54] Letter to Frank Church, chairman, Committee on Aging, from Michael Pertschuk, Director, Federal Trade Commission, Nov. 22, 1978.

[55] Speech, Robert A. Beck, Chicago, Ill., May 1, 1978. See also hearings cited in footnote 1, part 1, pp. 3–5. HIAA represents insurance companies which write 85 percent of the private health insurance in the country.

[56] Communication with HIAA staff. Survey not completed at time of publication of this report.

HEW ACTIONS

The Department of Health, Education, and Welfare announced that it would provide medicare beneficiaries with information to help evaluate supplementary insurance coverage in January 1979.

Secretary Califano said the Department would prepare special mailings to all beneficiaries, revise the medicare handbook and forms to provide explanations of supplemental policies, and work with senior citizen groups to distribute information.[57]

GAO SURVEYS

At committee request, the General Accounting Office undertook a preliminary survey of the capabilities of selected State insurance commissions to detect and deter medi-gap abuses.[58]

A second survey of a sample of elderly SSI beneficiaries in five States was undertaken by the GAO to determine the incidence of purchase of medi-gap policies by those elderly who already had both medicare and medicaid protection.[59]

Over 11 percent of the sample had purchased at least one medi-gap policy. Most of those who had purchased policies (79 percent) said they bought the policy to pay for medical expenses which they believed would not otherwise be covered.

Most of the sample (about 90 percent), however, were already participants in medicare and State medicaid programs. Since most State medicaid plans pay for medicare's major gaps, there would be little need for additional private insurance.[60] Information on specific benefit provisions of the medi-gap policies held by SSI recipients was not collected by the GAO, but it is unlikely that many purchasers would receive benefits from policies which would only pay what is not paid for after medicare and medicaid are both used up.

II. INCENTIVES FOR CONSUMER CO-OPS

The National Consumer Cooperative Bank Act, signed into law on August 20, 1978,[61] establishes a bank to provide loans to nonprofit consumer cooperatives. An Office of Self-Help Development and Technical Assistance, within the bank, is to provide technical assistance and support to nonprofit groups and organizations to develop self-help consumer cooperatives.

The bank is required to make at least 35 percent of its funds available to cooperatives which have a membership consisting largely of persons with low incomes. It must also give additional priority to other cooperatives providing services which will be used predominately by low-income individuals.

---

[57] Press release, Health Care Financing Administration, Department of Health, Education, and Welfare, Jan. 18, 1979.

[58] Survey not completed at time of this report.

[59] Survey conducted by GAO staff during October and November 1978. Questionnaires and data maintained in committee files.

[60] Most State medicaid plans, for instance, offer a "buy in" arrangement to elderly medicaid beneficiaries which pays for medicare's deductibles and coinsurance charges. In addition, most State medicaid plans provide payment for nursing home stays not covered by medicare, and for hospital stays beyond medicare's limits. Some also provide benefits for drugs, home health, and dental and eye care.

[61] Public Law 95–351. H.R. 2777, originally passed by the House of Representatives on July 14, 1977, by a vote of 199–198; passed by the Senate on July 13, 1978, by a vote of 60–33. A similar Senate version of the bill, S. 1010, was cosponsored by Committee on Aging members Church, Melcher, and Brooke.

The bill was strongly supported by major national aging organizations, which cited cooperatives as a viable competitive alternative to retail purchasing of food, clothing, furniture, and gasoline as well as services such as health care, housing, legal aid, and repair work.[62] During Senate hearings, testimony about existing cooperatives demonstrated their ability to lower prices to consumers.[63]

The bank is to be governed by a presidentially appointed 13-member board of directors. Seven of the directors are to be officers of Federal agencies and departments. Six directors must be members of the general public with extensive experience in cooperative development in the areas of housing, consumer goods, low-income cooperatives, and consumer services.

It is expected that the bank will begin operations during 1979. Public hearings will be conducted throughout the country during the year to solicit suggestions for priority areas of concern.

III. PROTECTION FOR ELECTRONIC FUND TRANSFERS

A bill to provide consumers with safeguards in automatic banking transactions, including direct deposits of social security checks and other retirement income, was signed into law on November 10, 1978 [64]

Direct deposit of social security and other retirement checks has proven to be an advantage to older Americans. Many have cited the increased protection against crime and robbery as direct deposit reduces chances for checks to be stolen, lost, or having endorsements forged. When checks are deposited directly, it also means that older Americans no longer have to cash their checks, risking carrying large amounts of cash. For others, it has meant elimination of troublesome monthly trips to a bank.

The Social Security Administration offered a direct deposit option to all beneficiaries in 1975. Almost 5 million beneficiaries, about 15 percent of the total population receiving social security benefits, were using the direct deposit option by the first quarter of 1977.[65]

Once the system was widely implemented, however, fears were expressed that direct depositors would no longer be able to keep track of the amounts in their bank account, and that they would no longer know exactly when their check arrived. As the implications of further advances in electronic fund transfer became more widely known, new fears rose about the security of electronic systems and consumer liability for fraudulent or unauthorized bank transactions.

Most of the provisions of Public Law 95–630 provide guidelines for regulation of bank officials and a number of banking transactions. The following provisions for consumer rights and safeguards in automated banking tellers, direct deposit transactions, and other electronic fund transfers, however, were included:

—Limits to $50 the liability of a customer for unauthorized fund transfers.

---

[62] Senate hearings on S. 1010 and H.R. 2777, Senate Subcommittee on Financial Institutions, Jan. 25 and 26, 1978. The National Council on Senior Citizens presented testimony in favor of the bill, and the National Association of Retired Teachers/American Association of Retired Persons submitted a statement urging the bill's enactment.

[63] Hearings cited in footnote 62.

[64] Public Law 95–630. The provisions were contained in H.R. 14279, which cleared Congress on Oct. 15, 1978.

[65] "Social Security Beneficiaries Using the Direct Deposit Procedure, June 1976," Research and Statistics Note, Office of Research and Statistics, Social Security Administration, Washington, D.C., 1978.

—Requires disclosure to consumers of terms and conditions of EFT transfers.
—Provides for rights to documentation of transfers and periodic statements of account.
—Establishes error resolution procedures.
—Provides for institutional liability for failure to make transfers or to stop payment of preauthorized transfers.

IV. RULES FOR HEARING AIDS AND FUNERALS?

Staff of the Federal Trade Commission's Bureau of Consumer Protection issued a final report on the FTC's proposed trade regulation rule for the sale of hearing aids in September 1978.[66]

The report was based on extensive hearings and rulemaking proceedings begun by the FTC in 1975. The FTC investigation and proceedings began after allegations were made that many older Americans with low incomes were spending large sums of money for hearing aid devices which did not perform as represented by dealers.[67]

The staff-recommended rule, geared toward a comprehensive approach to advertising and marketing of hearing aids, would cover the sale or rental of all hearing aids by sellers, distributors, physicians, and audiologists.

The recommended rule would:

—Require sellers to provide each buyer with the opportunity to cancel purchase within 30 days after delivery of the hearing aid, and inform the buyer of his right to cancel both orally and in writing. Sellers would be required to refund all payments made for the returned hearing aid, including finance charges and taxes. The seller could deduct, however, certain charges (up to about $50), depending upon circumstances of the original sale. Two earlier exemptions to this provision, for physician- or audiologist-prescribed aids and for replacement of identical aids, are no longer recommended by the FTC staff.[68]
—Require sellers to disclose their status as sellers of hearing aids and prohibit any statements which would lead consumers to believe they were hearing experts or specialists.
—Prohibit false or misleading claims regarding the performance of a hearing aid; including claims that a hearing aid would restore normal hearing, would retard the progression of hearing loss, or would shut out all unwanted background noise.

---

[66] "Hearing Aid Industry Staff Report. Final Report to the Federal Trade Commission and Proposed Trade Regulation Rule, 16 CFR Part 440," Bureau of Consumer Protection, Federal Trade Commission, September 1978. The new "plain English" version of the proposed rule is contained in the staff report. Notification of its availability was published in the Federal Register on Nov. 20, 1978 (43 CFR 54103).

[67] For further information on the FTC rulemaking process for hearing aid sales, see "Developments in Aging: 1976," part 1, pp. 156–157, Senate Report No. 95–88, U.S. Senate Special Committee on Aging. Also see report cited above for discussion of regulations promulgated by the Food and Drug Administration to establish uniform professional patient labeling requirements and conditions for sale of hearing aid devices. Proceedings were initially undertaken after Committee on Aging hearings had documented widespread instances of abuse in the sale of hearing aids to older Americans: "Hearing Aids and the Older American," hearing of the Senate Special Committee on Aging, Subcommittee on Consumer Interests of the Elderly, Sept. 10, 1973.

[68] The rules, as originally proposed in 1975, specified that if an audiologist or a physician had recommended, or prescribed, a specific hearing aid model, the seller would be exempt from the 30-day right to cancel provision. The 1975 proposed rule also exempted sellers who had replaced an identical aid. Both these exemptions have been removed from the recommended rule.

—Require oral consumer consent to a home sales visit before coming to the home to make a sales presentation.[69]

—Require sellers who advertise aids with a phone option to disclose, in the advertising, that the phone option may not be compatible with all phones in the area.

The FTC staff found that about 650,000 hearing aids are purchased every year, at an average price of $350 each. Most are purchased without the involvement of a medical specialist. About half the sales take place in the home.[70]

Staff also found a "multitude of abusive sales transactions and sales tactics" within the hearing aid industry, including selling used hearing aids as new, and claiming that hearing aids will help restore normal hearing power.[71]

The recommended rule is intended to supersede only those State laws and regulations which do not provide consumers with equal or greater protection than the FTC rule.

The rule has not yet been accepted by the Commission. An additional 60-day comment period on the recommended rule will be open until January 19, 1979. The FTC may either extend the comment period then, or act on the final rule.

FUNERAL INDUSTRY PRACTICES

In June 1978, the FTC issued its final staff report on a proposed trade regulation rule on funeral industry practices. The report, based on extensive public proceedings and hearings covering a period of 3 years, concludes that new rules are required to eliminate abuses within the funeral industry.[72]

The recommended rule would:

—Prohibit practices which take unfair advantage of the grief-stricken state of funeral purchasers, including unauthorized removal of remains, embalming without permission, requiring a casket for cremation, and overcharging on items such as flowers and obituary notices;

—Prohibit misrepresentations by funeral directors of legal, religious, and cemetery requirements for funerals, including the preservative or protective value of embalming, caskets, and burial vaults;

—Prohibit selling techniques which unfairly or deceptively interfere with the consumer's ability to freely select a funeral, including attractive display of expensive items only and misrepresentation of the availability of merchandise;

—Require disclosure of prices, including furnishing consumers with price lists for funeral items before purchase and quotation of prices over the phone and through the mail; and

—Prohibit funeral directors from interfering with memorial society arrangements.

---

[69] The 1975 proposed rule would have required written consent to a home sales visit.

[70] Report cited in footnote 65.

[71] Reported cited in footnote 66.

[72] 16 CFR part 453. "Funeral Industry Practices," final staff report to the Federal Trade Commission, and Proposed Trade Regulation Rule. Bureau of Consumer Protection, Federal Trade Commission, June 1978. See "Developments in Aging: 1976," part 1, U.S. Senate Special Committee on Aging, Senate Report No. 95-88, pp. 157-161 for further discussion of rule as originally proposed in 1975 and for comment and reaction to the rule during 1976.

Staff found that consumers spend about $6.4 billion annually on funeral, burial, and related expenses. An average funeral costs over $2,000.[73]

Final rules are not expected until sometime during 1979.

---

[73] Report cited in footnote 72.

CHAPTER VII

A REVISED OLDER AMERICANS ACT

Congress altered the Older Americans Act significantly in 1978, assigning new responsibilities to units in the aging network and regrouping major service titles.

As agreed to by House-Senate conferees on September 23, the Comprehensive Older Americans Act[1] Amendments of 1978 (signed into law as Public Law 95–478 on October 18), includes these features:

—A new comprehensive title III which now encompasses nutrition (formerly title VII) and multipurpose senior center funding (formerly title V), as well as social services. This means that area agencies will become the channels for funds formerly provided separately through State agencies for nutrition services and senior centers. In signing the bill, President Carter said: "We are improving these services by strengthening their coordination and planning at all levels of Government. . . . They also improve planning for these services to add efficiency at all levels of Government and eliminate countless hours of paperwork and administrative burdens."

—The act is extended through 1981; a 3-year planning cycle replaces the present 1-year State and area planning requirement.

—The advocacy function of the Administration on Aging and the State and area agencies is sharpened.

—The AoA is also instructed to maintain active review and comment on all Federal policies affecting the aging. This broad change also assigns AoA a strengthened involvement "in development of policy alternatives in long-term care and to insure that the development of community alternatives is given priority attention." Another section authorizes grants for community long-term care model projects.

—Area agencies on aging are to "target" 50 percent of their social service allocations on in-home, access (transportation outreach, information and referral, etc.), and legal services.

—New authority is provided for home-delivered meals.

—Senior centers as focal points for actual delivery of services are emphasized throughout; funding for center personnel, operating costs and limited construction is added to the earlier authority for center renovation.

—A national manpower policy on aging is mandated.

—A nursing home ombudsman program is required of each State agency on aging to monitor and investigate complaints from residents of nursing homes or their families.

---

[1] Enacted in 1965, the Older Americans Act had earlier been amended and extended in 1967, 1969, 1972, 1973, and 1975. Eligibility for services extends to all persons 60 years or older except for the title V employment program which has an eligibility age of 55 and over.

—A new title is authorized to allow Indian tribes and tribal organizations the option of receiving direct funding from the Commissioner of the Administration on Aging.

—The community services employment programs eligibility is liberalized by allowing persons with 125 percent of the poverty guidelines to participate.

I. 1978 EXTENT OF OLDER AMERICANS ACT OPERATIONS

What is often called "aging network" under the Older Americans Act has grown markedly since area agencies on aging were first established under 1973 amendments to the act.[2]

Early in 1978, the agencies and programs already in place had these dimensions:

—All 50 States and 5 territories had State units on aging, which employed more than 1,300 persons. These offices are responsible for coordinating their efforts with other State programs, including health services, transportation programs, educational programs, employment programs, income maintenance programs, etc., which could provide assistance to the elderly.

—The 558 area agencies on aging within 612 planning and service areas employ approximately 6,000 persons and enlist 14,000 volunteers. These agencies were responsible for tapping approximately $200 million per quarter for elderly services from other resources, including 21 percent from local funding, 9 percent from State funding, and 70 percent from Federal funding. The area agencies served about 4,686,000 older persons each quarter during 1978, including 44 percent who were low-income and 18 percent who were minority (3 percent American Indian, 58 percent black, 6 percent oriental, 22 percent of Spanish origin and 11 percent "other minority").

—There were 9,732 nutrition sites operating during 1978 under the administration of 1,074 nutrition projects. These sites employed about 22,000 persons and had 127,000 volunteers (82 percent of whom were elderly). More than 1,534,000 persons enjoyed meals at the nutrition sites, 66 percent were low-income and 22.5 percent were minority (6.4 percent American Indian, 61.8 percent black, 3.4 percent oriental, 18.1 percent of Spanish origin and 10.3 percent of "other minority"). The sites served approximately 470,000 meals per day—83 percent in congregate, community sites and 17 percent to the homebound.

—There were 1,100 senior centers supported by the Older Americans Act during the last year. Centers were in every State as separate facilities or within housing complexes, churches, schools, community centers, and recreational facilities.

---

[2] For a detailed description of the aging network, see chapter V of "Developments in Aging: 1976," part 1, a report of the Special Committee on Aging, U.S. Senate.

II. THE NEW FRAMEWORK

Administration on Aging Commissioner Robert Benedict, testifying early last year on extension of the Older Americans Act, posed these questions:

> How can we insure that our support systems in the community respond effectively to the widely varying circumstances of the elderly and their families?
>
> How can we make certain that the efforts of government actually enhance and add to the compassionate care and support of families for their elders?
>
> How can we halt the fragmentation, waste, and duplication which have come with the proliferation of programs for the elderly at every level of government? [3]

Responding to these and other challenges, the House and Senate architects of the new amendments developed new strategies and mechanisms, including as a centerpiece the new alignment of service titles.

A. CONSOLIDATING TITLES III, V, AND VII

Every major bill offered early in 1978 to extend the Older Americans Act offered varying forms of consolidation.

Senator Thomas Eagleton described the consolidation provision contained in his bill (S. 2850) as insuring "that coordination and cooperation among the various programs contained under the umbrella of the Older Americans is achieved. . . . It is my belief that all Older Americans Act programs should be implemented through this central network so that a focal point for services to the elderly can be established in each community in order to insure a proper coordination of services." [4]

Senator Pete Domenici authored the consolidation in S. 2609—applying only to titles III and V—as a "reform which will streamline the planning procedures, lessen the paperwork burden at all levels of government, and improve the coordination of services to our senior citizens." [5]

"Our bill, S. 2969," said Senator Frank Church, would simply attempt to enhance the effectiveness and efficiency of the act by requiring the States and area agencies to have one comprehensive plan which would include all of the services provided under new title III. It would also reduce the paperwork burdens for State and local personnel." [6]

In cosponsoring S. 2609, Senator Charles Percy stated that "from numerous hearings conducted by the Aging Committee, both in Washington and throughout the country, we found that coordination of various programs needed to be improved; that paperwork needed to be reduced . . . this bill represents the practical approach." [7]

---

[3] Testimony by Commissioner Robert C. Benedict, Administration on Aging, before the U.S. Senate Subcommittee on Aging, Apr. 21, 1978.

[4] Statement of Senator Thomas Eagleton upon introduction of S. 2850 to extend the Older Americans Act, Apr. 6, 1978.

[5] Statement of Senator Pete Domenici upon introduction of S. 2609 to extend the Older Americans Act, Feb. 28, 1978.

[6] Statement of Senator Frank Church upon introduction of S. 2969 to extend the Older Americans Act, Apr. 20, 1978.

[7] Statement of Senator Charles Percy upon introduction of S. 2609 to extend the Older Americans Act, Feb. 28, 1978.

Most of the national aging organizations supported the consolidation of service titles. However, the National Association of Title VII Directors expressed opposition to such a merger on grounds "that a decision of such magnitude should not be made at the Federal or State level but at the local level among those parties involved." [8]

The National Council of Senior Citizens assessed the pros and cons of such a consolidation.

> In principle, there would appear to be scant reason to oppose streamlining the planning process by this measure. . . . If the merger currently discussed is but an incremental step towards eventual amalgamation of the authorizations into a bloc grant, we would strenuously oppose the move.[9]

The final legislation—Public Law 95–478—reflected these varying views by consolidating the service titles, but including separate authorizations or special emphasis language to show the intent of Congress as to which programs should be continued or emphasized.

THE FINAL AGREEMENT

Under the new consolidated title, part A of title III contains the administrative framework for all of the service programs. Therefore, all social services, nutrition services, and senior center programs will be governed by the general provisions related to authorizations, allotment formulas, organizations, area plans, State plans and administration outlined in part A.

Part B lists the social services and senior center activities supported under title III. All services with the exception of the congregate and home-delivered nutrition services are authorized under this part.

Part C provides for the authorization of a congregate nutrition program under subpart 1 and a new home-delivered meals program under subpart 2.

AUTHORIZATIONS

The new title III authorizations were increased substantially to allow for an expansion of existing programs, support of new programs and the inclusion of senior centers under the social services authorization. However, the 95th Congress ended without providing appropriations for fiscal year 1979.[10] Therefore, all programs under the act were funded in fiscal year 1979 under a continuing resolution which continues existing programs at the "current rate." Several programs authorized by the new amendments did not exist in fiscal year 1978. These programs cannot be implemented until appropriations legislation is enacted.

---

[8] Statement of National Association of Title VII Directors, before the U.S. House of Representatives Subcommittee on Select Education, Mar. 13, 1978.

[9] Statement of the National Council of Senior Citizens, before the U.S. Senate Subcommittee on Aging, Feb. 8, 1978.

[10] Appropriations legislation for the Older Americans Act was not enacted by the 95th Congress because the legislation extending the act for fiscal years 1979–81 was not signed into law before the beginnnig of fiscal year 1979, Oct. 1, 1978. Additional funding for these programs can be included in a supplemental appropriations bill.

The 1978 amendments authorized the following ceiling levels for the social services and nutrition programs:

[In millions of dollars]

	Fiscal years		
	1979	1980	1981
Social services	$300	$360	$480
Congregate nutrition	350	375	400
Home-delivered meals	80	100	120

ALLOTMENT FORMULA

Title III's allotment formula continues to be a formula grant program which allocates each State an amount equal to the States' proportion of persons aged 60 and over. Under the new title III, each State will receive four allotments: one for administration, one for social services, one for congregate nutrition programs, and one for home-delivered meals programs.

The new amendments also specify that each State may use up to 8.5 percent of its title III allotment for administration of area agencies on aging. This new formula, proposed by Senator Frank Church and Representative John Brademas (S. 2969 and H.R. 12255), allows Older Americans Act funding to be used to support 75 percent of the cost of administration—for area agencies as well as State agencies. State and local agencies will be responsible for meeting the other 25 percent. For social services, the non-Federal match will be 10 percent until 1981 when the percentage is to be increased to 15. The new amendments require that the increase in 1981 must be the responsibility of the State. The non-Federal share may be in cash or in-kind but at least 25 percent of the non-Federal match must be cash.

B. ORGANIZATION

Public Law 95–478 is consistent with the former organization of State and area agencies but provides for additional responsibilities by them.

State agencies on aging are now required to:

- —Serve as effective and visible advocates for the elderly by reviewing and commenting upon all State plans, budgets, and policies which affect the elderly and providing technical assistance to any agency, organization, association or individual representing the needs of the elderly. This language was proposed by Senator Frank Church in recognition of the aging network's responsibility and impact as an active advocate.
- —Develop a formula for the distribution of title III funds within the State taking into consideration the geographical distribution of persons 60 years of age and over and then making this formula available to the public for review and comment.
- —Provide assurances that preference will be given to providing services to those elderly with the greatest economic or social need.
- —Allow a unit of general purpose local government of 100,000 popu-

lation or more to apply for designation as a single planning and service area and be afforded the opportunity for a hearing if they are dissatisfied with the State's decision; and

—Allow the chief executive officers of each State involved to apply to the Commissioner for designation of an interstate planning and service area, including interstate Indian reservations.

AREA PLANS AND "TARGETING"

The area plan requirements of an agency designated as an area agency on aging will continue under the new law with the following changes:

—A requirement that the area agency develop a 3-year plan with annual amendments as necessary.

—A requirement that the plan will provide assurances that at least 50 percent of the area agency's part B social services allotment is spent on access services (transportation, outreach and information and referral) in-home services (homemaker, home health, chores services, and so forth) and legal services; however, the State agency may waive this requirement 'f the area agency can show how it is meeting these services with other resources.

This formula for targeting services was proposed by Senator Eagleton, Chairman of the Human Resources Committee's Subcommittee on Aging, who was concerned that the scattering of Federal dollars among many services results in a large number of ineffective services.[11] Therefore, he proposed a concentration of the dollars in these targeted areas. Area agencies are also required to:

—Provide assurances that the area's plan will show how preference is being given to providing services to those elderly with the greatest economic or social need; and

—Serve as the "advocate and focal point for the elderly within the community" by monitoring and commenting upon all policies which affect the elderly.

Again, this language was proposed by Senator Church in an effort to define more clearly the role of advocacy for each agency in the aging network. Until the 1978 amendments, the advocacy role had been implied but now it has been legislatively defined as a major responsibility of each agency.

STATE PLANS AND NEW RURAL EMPHASIS

The State plan would also be changed from an annual document to a 3-year presentation with annual adjustments as necessary. Other new requirements include:

—Authorizing the State to base its State plan on the contents of the plans developed by the area agencies and to develop a uniform format for the areas to follow in developing their plans.

—Mandating the State to increase its spending on social services, nutritional services, and senior centers in rural areas by 5 percent above what the State was spending in these areas in 1978. (However see exceptions on page 113.)

---

[11] For additional discussion of Senator Eagleton's emphasis on "targeting" see pp. 149–153 "Development in Aging 1977."

This provision was based upon Senator Domenici's floor amendment to change the national allotment formula so that those States having the largest number of rural elderly would receive an allotment which gave additional weight to that per centum of the population of the State's elderly who reside in rural areas. Senator Domenici described this amendment as modifying the current formula to "allow a greater recognition of the special needs of the older Americans who live in rural areas." [12]

Additional provisions affect State-area relationships by:

—Allowing the State agency to give an opportunity for a hearing to any area agency submitting a plan under title III, any service provider under the plan, or any applicant to provide a service under the plan;

—Mandating each State agency to support with 1 percent of their title III, part B social services allotment or $20,000, whichever is greater, a statewide nursing home ombudsman program which will be responsible for investigating and resolving complaints of residents in nursing homes—including such duties as data collection, developing procedures for access to facilities as well as patients records, and providing technical assistance and training for volunteer and citizen organization groups to participate in the ombudsman program.

C. HOME-DELIVERED MEALS

State agencies are authorized to provide a congregate nutrition program and a home-delivered meals program to persons aged 60 and over and spouses. Contributions received for meals are to be used to increase the number of meals served. Each project must provide outreach efforts. The use of nutrition funds for supportive services (up to 20 percent of the nutrition budget except in those areas with high supportive services costs where the Commissioner can approve requests up to 50 percent) is continued for only 2 years.

The home-delivered meals program will be funded as a separate program for the first time under the Older Americans Act. The efforts to support a separate authorization, were led by Senators Kennedy, Church, McGovern, Dole, and Percy, who stressed the need to keep the elderly in their homes where they want to be and at the same time provide them with nutritional meals and contacts with the outside world. The home-delivered meals programs, as well as the congregate nutrition programs, will all be administered through the area agencies, as required under the consolidation. This consolidation also is the basis for the discontinuation after 2 years of the supportive services funding under the nutrition program. In order to encourage coordination with the nutrition program and other services under title III, the new law requires that by fiscal year 1981 the cost of supportive services under the nutrition program must be met by funds under part B, social services funds. Senator Church, who offered the amendment to allow a 2-year continuation of funding for supportive services, stressed:

> A 2-year grace period is needed to permit the State to work with the nutrition programs to develop a comprehensive

---

[12] Statement by Senator Pete Domenici upon introduction of an amendment to the formula of the Older Americans Act, July 24, 1978.

> service system that will satisfactorily coordinate the nutrition services with other programs.[13]

D. SENIOR CENTERS

State agencies may approve the use of title III, part B funds for the acquisition, renovation, and alteration of facilities to be used as senior centers and allow such funds to be used for limited construction and to support operational and staffing costs.

Although the act no longer provides for a separate authorization for senior centers, language in title III emphasizes centers as community focal points for the delivery of services. In addition, in describing requirements for nutrition sites, the law states that particular attention be given to multipurpose senior centers.

House and Senate conferees stated their intent that senior centers continue to receive support by the act in conference report:

> The conferees emphasize the importance of multipurpose senior centers in developing a comprehensive social services network and expect that area agencies will continue to place appropriate emphasis on their development and expansion.

E. LEGAL SERVICES

Legal services funded under title III are to be provided by a legal services corporation program or a program which provides legal services to older persons with the greatest economic or social need, who agree to coordinate their efforts with existing legal services corporation projects. Such legal services will be in addition to any legal services being furnished by the provider with funds from sources other than the Older Americans Act.

The targeting of legal services was advanced in legislation by Senator Kennedy and Representative Brademas, who called for a separate authorization for legal services under title III.[14] However, the final legislation incorporated legal services as one of the targeted services under title III, recognizing its impact as a tool for providing other necessary benefits to the elderly—income, health care, tax counseling, et cetera. Therefore, each area agency will be required under the new amendments, to make legal services available for their elderly population through the use of title III funds or other sources included in their area plan.

Although the new amendments require major changes in administrative mechanics, waivers are allowed for a 2-year period to allow State and area agencies time to make the necessary transition. Each State is allowed to waive any provisions of the consolidation for fiscal years 1979 and 1980 provided the area agency shows it is making good faith efforts toward the requirements of consolidation. In addition, each State agency is allowed to waive the rural formula if the service needs of the elderly in a particular rural area are being met or if the number of individuals living in a particular area is not sufficient to warrant the increase provided under the formula.

---

[13] Statement by Senator Frank Church upon introduction of amendment to nutrition program under Older Americans Act, July 24, 1978.

[14] S. 2394 by Senator Kennedy and H.R. 9079 by Congressman Brademas.

F. ADMINISTRATION

As described earlier, each State receives an administration allotment based on its 60-and-over population. The new amendments increase the minimum a State may receive under the formula to $300,000 for small States and $75,000 for the territories.

In addition, the administration section allows a State, with the approval of the Commissioner, to transfer funds between its congregate nutrition allocation and its home-delivered meals allocation, if conditions warrant.

G. DISASTER RELIEF

The new law allows the Administration on Aging to reimburse a State for services provided during a Presidentially declared disaster; up to 5 percent of the funding for model projects may be used. The law states that the Commissioner shall reserve the 5 percent up to the third quarter of the fiscal year for disaster reimbursement and then proceed to use any remaining fraction of the 5 percent to support model projects.

H. SURPLUS COMMODITIES

The new amendments continue the availability of USDA surplus commodities for nutrition projects and continues the option for each project to elect cash in lieu of commodities. The commodities or cash are provided in accordance with the number of meals served by the projects and the 1978 amendments increase the price per meal to at least 30 cents, as adjusted by the Consumer Price Index.

III. SOCIAL AND NUTRITION SERVICES AUTHORIZATION

Under the new structure created by the 1978 amendments, part B authorizes the continuation of social services as provided under title III in the past. In addition, the authorization for senior centers is included in this part.

Part B specifically identifies health services, continuing education, welfare services, information and referral, recreational, homemaker, counseling services, transportation services, housing, alternative services to institutionalization, legal services, tax and financial counseling, physical activity, health screening services, preretirement and career counseling, ombudsman services and "any other services if such services meet standards prescribed by the Commissioner and are necessary for the general welfare of older individuals."

NUTRITION SERVICES

Title III's part C, subpart 1, authorizes the continuation of congregate nutrition programs which 5 days or more each week, provide at least "one hot or other appropriate meal" which provides at least one-third of the daily recommended dietary allowances. The law also allows each nutrition project to provide nutrition education and other appropriate nutritional services for its participants.

Subpart 2 sets forth the newly created home-delivered meals program for the elderly and requires each project to provide at least five meals per week which are "hot, cold, frozen, dried, canned, or supplemental foods (with a satisfactory storage life)" and provide at least one-third of the daily recommended dietary allowances.

In addition, this subpart requires the Commissioner to develop minimum criteria, with advice by nutrition organizations, to guide the efficiency and quality of the home-delivered meals.

IV. THE EXPANDED TITLE IV

In addition to research, training and multidisciplinary centers of gerontology, the new title IV authorizes all demonstration projects including special demonstrations for long-term care, legal services, national impact demonstrations, and utility and home heating cost demonstrations.

A. Training

Public Law 95-478 requires the Commissioner to develop a national manpower policy on aging which represents the present and future need for personnel in all programs serving the elderly. This national policy, which was based on Senator Church's bill (S. 2969), was developed to assist the Administration on Aging in overcoming its past training efforts which "have been fragmented and small." [15]

The new law requires that the manpower policy shall give priority to the training of persons involved with the operation of senior centers and nutrition projects. In addition, the law requires that the policy be implemented in cooperation with other departments and agencies including the Public Health Service, the Social Security Administration, the National Institutes of Health—particularly the National Institute on Aging—the Administration for Public Services (title XX), the Rehabilitation Services Administration, the Department of Labor, the Department of Transportation, the Department of Housing and Urban Development, and other appropriate agencies.

B. Research

Research efforts of the AoA in the past were largely contracted out to individuals and institutions of higher education. The new law, however, requires the Commissioner to make grants or contracts to any public agency or nonprofit private organization or institution for the purpose of conducting specific mandated research efforts: a study analyzing the problems experienced in operating transportation services with emphasis on the difficulties in obtaining insurance for high occupancy vehicles; a study related to the revision of existing Federal transportation systems to provide more coordinated and comprehensive services doing away with unnecessary duplication among such programs; a study analyzing methods to eliminate differences in eligibility requirements in transportation programs; and a study related to the differences in access to and the unit costs of services delivered in rural areas and urban areas.

---

[15] Statement by Senator Frank Church upon introduction of S. 2969 to amend the Older Americans Act, Apr. 20, 1978.

The new law requires that the results of the mandated studies be reported to the Congress no later than 2 years after enactment of the amendments (October 18, 1978) and be made available to the public through the National Information and Resource Clearing House of the Administration on Aging.

C. DEMONSTRATION PROJECTS

Formerly a part of title III, the demonstration or model projects are now authorized under title IV. Part C of title IV continues to allow the Commissioner on Aging to make grants and contracts to public agencies or nonprofit private organizations, for the purpose of supporting "statewide, regional, metropolitan, county, city, or community model projects" which will demonstrate effective methods of providing social or nutrition services to older persons. The Congress describes certain areas in which the Commissioner is required to fund demonstration projects including, alternative health care delivery systems, advocacy and outreach programs and transportation services. In addition, the Commissioner is required to give special consideration to funding projects which demonstrate innovative methods of providing housing for the elderly, property tax relief, continuing education, preretirement education and training, special services for the physically and mentally impaired elderly and ambulatory day care centers. Further demonstration projects are encouraged which show methods of meeting the special needs of the rural elderly and methods of coordinating all available social services for the homebound elderly, the blind, and the disabled.

D. SPECIAL PROJECTS IN LONG-TERM CARE

The need for a comprehensive long-term care program for the elderly was recognized in most of the legislative proposals to amend the Older Americans Act.

Senator Lawton Chiles discussed the need for a comprehensive program when he introduced S. 2967, a bill to provide special projects in long-term care under the Administration on Aging:

> Too often, noninstitutional long-term care services are available only on a piecemeal basis: skilled home nursing may be available, but not equally needed maintenance support, such as a homemaker or chore services . . . The needed services are not often all present in the same community. If they are in place, they are rarely fully coordinated with each other so that support needed by a single person at different times can be efficiently determined and met.[16]

Congressmen William Cohen, Claude Pepper, and John Brademas, and Senators Domenici and Church also included long-term care initiatives in their legislation, recognizing the need for the Administration on Aging, in cooperation and coordination with other health and services agencies, to develop a comprehensive system to meet the total needs of the elderly for long-term care.

---

[16] Statement of Senator Lawton Chiles upon introduction of S. 2967, a bill to amend the Older Americans Act, Apr. 20, 1978.

Public Law 95-478, therefore, includes a special demonstration section authorizing the Commissioner on Aging to make grants to selected State and/or area agencies, institutions of higher education, and other public agencies and nonprofit private organizations, associations or groups to support the development of a comprehensive long-term care system for the elderly.

This system should include alternative services to institutionalization, an assessment of need of the individual, the development of a plan of care, and the referral of the individual to the appropriate level of care. The programs to be coordinated into a comprehensive system could include adult day health, monitoring and evaluation of services effectiveness, supported-living in public and private nonprofit housing, family respite services, preventive health services, home health, homemaker services as well as other rehabilitative and maintenance inhome services, geriatric health maintenance organizations, and other appropriate services.

Applicants for the special long-term care demonstrations must assure that adequate State standards are developed to insure the quality of services; that the State has a commitment to carry out the long-term care program with the agency responsible for administering medicaid—title XIX—and the title XX social services; that the State will develop plans for financing the comprehensive system designed to meet the long-term care needs; and that the State has a plan for a statewide or regional basis to provide access to the services provided under the comprehensive system.

The long-term care special demonstration project funds may not be used to support the cost of services which are eligible for reimbursement under medicare—title XVIII—medicaid—title XIX—or title XX social services.[17]

E. Special Demonstrations in Legal Services

In the past, the Commissioner has made grants under model projects to support legal service programs for the elderly, technical assistance in the legal problems of the elderly and training of paralegals to work with the elderly. The new amendments authorize a special section under part C, model projects, to support legal research, technical assistance, training, information dissemination, and other support activities to agencies, organizations, institutions and the private bar that can show the capabilities of providing, developing, or supporting pro bono or reduced-fee legal services to elderly persons. The section also supports demonstration projects which show methods of expanding or improving the delivery of legal services to the elderly.

The new amendments required that at least $5 million of the funds appropriated for model projects under title IV be used to support legal services demonstration projects.

F. Other Special Demonstrations

In addition to special projects in long-term care and legal services, the 1978 amendments authorize two additional special demonstrations. First, the Commissioner is authorized to make grants or contracts to support demonstrations of national significance to show methods of improving or expanding the overall delivery of services to the elderly on a nationwide basis.

---

[17] For additional discussion of comunity-based long-term care, see page 84.

Special demonstrations in providing elderly relief from utility and home heating costs are also supported under title IV. Such projects are to demonstrate methods of relieving the burden of such costs to the elderly, such as reduced rates by private business and public utilities.

V. TITLE V—COMMUNITY SERVICE EMPLOYMENT

The new amendments redesignate the former title IX, community service employment for older Americans, as a new title V. However, the program remains substantially the same—to provide part-time job opportunities in community service for low-income persons aged 55 years and older. The program is administered by the Department of Labor.

Under Public Law 95–478, several major changes were made in the community service employment program and increased authorizations were provided. The House and Senate conferees agreed to authorizations for 3 years—$350 million for fiscal year 1979, $400 million for fiscal year 1980, and $450 million for fiscal year 1981. However, appropriations for title V, like the entire Older Americans Act, have also been maintained at the fiscal 1978 level—$250 million—under the continuing resolution. Unless actual appropriations are enacted, the increased authorizations cannot be realized.[18]

Major changes made in the new title V include raising the definition of low income to 125 percent of the poverty index. This will enable near-poor as well as the poor to participate in the program. Senator Church, who sponsored the eligibility expansion, explained:

> The overall emphasis would still be on low-income elderly because their needs are the greatest. But there are many instances where individuals with incomes slightly above the poverty levels are in as great need, if not greater.[19]

In the past, title IX job slots were largely administered by national organizations under the auspices of the Department of Labor.[20] The 1978 amendments direct more slots to the States by changing the allocation formula by stipulating that any additional funding in succeeding fiscal years will be allotted at 55 percent for the States and 45 percent for the national organizations. The national contractors will, however, retain at least the number of job slots they had during fiscal year 1978.

In addition, each national organization conducting a community service employment program must submit to the State in which the program is located, a description of the program 30 days prior to the implementation date.

---

[18] Appropriations legislation for the Older Americans Act was not enacted by the 95th Congress because the legislation extending the act for fiscal years 1979–81 was not signed into law before the beginning of fiscal year 1979, Oct. 1, 1978.

[19] Statement of Senator Frank Church upon introduction of S. 2969 to extend the Older Americans Act, Apr. 20, 1978.

[20] National Council on the Aging, National Council of Senior Citizens, American Association of Retired Persons, National Farmers Union, and the Forest Service have been the contractors in the past. In 1978, the Department of Labor made a decision to expand the list to include the Associacion Nacional Pro Personas Mayores and the National Center on Black Aged and Urban League.

The new law also directs the Secretary of Labor to reserve up to 1 percent of the appropriations over the fiscal year 1978 level for efforts to improve the transition from a community service employment job to the private sector. When this amendment was offered by Senator Domenici on the Senate floor he noted that similar efforts are being made in other programs, such as the CETA program, but no such effort is being made in the community service employment program for senior citizens.[21]

Domenici went on to explain that his amendment:

> . . . would seek to increase the turnover in the title V program. As older workers come into the program and develop job skills, improve working habits, and renew self-assurance, the opportunity begins to arise for placement in the private sector. . . . where it can be done. I think it will benefit the older worker, the program, and those yet unserved.

The Secretary is also directed to create a new part-time program, in consultation with the Environmental Protection Agency and the Department of Energy, which will relate to environmental improvement and energy conservation. This program is an outgrowth of a small joint project involving EPA and AoA.

VI. TITLE VI—DIRECT FUNDING OF INDIAN TRIBES

A new title VI was enacted to give Indian tribes and tribal organizations the option to be directly funded by the Commissioner on Aging. Thus, tribes receiving funds under the Older Americans Act may choose between direct funding or funding through the State or area agencies on aging.

To be eligible for direct funding, a tribe or tribal organization must have at least 75 elderly members age 60 and over and demonstrate the ability to deliver social and nutrition services. The tribe's application must show how it intends to develop a comprehensive service system for its elderly tribal members.

This new method of funding was authorized by Senator Domenici (S. 2609) in an effort to give the tribes more autonomy in managing their own programs for the elderly. Direct funding is already authorized in other Federal programs, including the comprehensive employment and training program (CETA) and the State and Local Fiscal Assistance Act of 1972 (revenue sharing).

The new title VI also allows surplus educational facilities to be used as multipurpose senior centers, nutrition centers, long-term care facilities, and so forth. This measure was sponsored by Senator Domenici to "allow us to significantly expand Indian services while taking full advantage of existing surplus facilities."[22]

In order to provide sufficient funding for the tribes, the act requires that at least $5 million be appropriated for title VI before it can be implemented. Because these programs are under a continuing resolution, with no provision for new programs, title VI will not be funded until appropriations legislation is enacted.

---

[21] Statement by Senator Pete Domenici upon introduction of a floor amendment to the Older Americans Act, July 24, 1978.

[22] Statement by Senator Pete Domenici upon introduction of S. 2609 to extend the Older Americans Act, Feb. 28, 1978.

CHAPTER VIII

CHANGES IN ACTION, CSA

Significant changes were made in programs serving or enlisting older persons when the Congress extended the Community Services Administration and ACTION agency during 1978.

In addition, President Carter's reorganization project focused, in a staff working paper, on proposals which could move the ACTION and CSA aging programs to the Administration on Aging in the Department of Health, Education, and Welfare.

This option was justified as "strengthening the Administration on Aging's role as the principal Federal agency for older people and providing opportunities to coordinate more effectively programs designed specifically for older persons. . . ."[1]

At year's end, the Office of Management and Budget was analyzing final draft recommendations of the President's reorganization project, but details were not yet public.

I. ACTION PROGRAMS

Congress gave close scrutiny to ACTION's Older American Volunteer programs (OAVP) during 1978. The performance and goals of programs for Retired Senior Volunteers, Foster Grandparents, and Senior Companions were examined in the wake of an administration-proposed budget cut and change in focus for the Retired Senior Volunteer program,[2] and charges were also received from program participants and major aging organizations that the ACTION agency was not demonstrating a commitment to the goals of the OAVP.

The outcome of the reauthorization process reaffirmed congressional commitment to the unique nature of the Older American Volunteer programs, which now give opportunities for community involvement and activity to 269,350 Americans age 60 and over.[3]

A. OLDER AMERICAN VOLUNTEER PROGRAMS REAUTHORIZED FOR 3 YEARS

The Retired Senior Volunteer program, Senior Companion program, and Foster Grandparent program were reauthorized for 3 years—through fiscal year 1981—by the Comprehensive Older Americans Act Amendments of 1978.[4]

---

[1] Staff working paper, Human Services Study, President's reorganization project, July 1978. (This paper is for background information only and does not represent any final conclusions and recommendations of the President's reorganization project.)

[2] See "Developments in Aging: 1977" part 1, Senate Report 95–771, Special Committee on Aging, U.S. Senate, pp. 215–216, for discussion of administration proposals for fiscal year 1979.

[3] Fiscal year 1978 enrollment was 269,350. Fiscal year 1979 enrollment was projected to be 269,900. See "Developments in Aging: 1978" part 2, for complete description of volunteer activities as reported to the committee by the ACTION agency.

During 1978, the Retired Senior Volunteer program enrolled 250,000 volunteers age 60 and over. The Foster Grandparent program, which provides low-income Americans age 60 and over with opportunities to work with children with special needs, had 16,250 participants during the year. Senior Companions, who must also be age 60 and over and have low incomes, provide volunteer services to other older Americans with special needs. Approximately 3,100 Senior Companions worked with other elderly as friendly visitors, providing transportation, chore services, and other similar services during 1978.

B. FUNDING AUTHORIZATIONS INCREASED

Action taken by Congress significantly increased the authorization levels for the Older American Volunteer programs as follows:

[In millions of dollars]

	Fiscal year 1978 appropriation	Fiscal year 1979 administration budget request	New authorization, fiscal year		
			1979	1980	1981
RSVP	20.1	15.4	25	30.0	35
FGP/SC	41.9	42.54	55	62.5	70

Increased appropriations for fiscal year 1979, however, were not approved by Congress by the end of the 95th Congress. Public Law 95–482, signed by the President on October 18, 1978, continued funding for fiscal year 1979 at the fiscal year 1978 appropriations level. A supplemental appropriations bill will have to be passed by Congress early in the 96th Congress if any program growth is to occur.

C. PROGRAM CHANGES

A number of significant program changes were made by Congress in addition to increases in the authorized funding levels.

Closer coordination with State agencies on aging and community action programs: Public Law 95–478 contains provisions to insure that State agencies on aging and community action agencies will be given preference for grant awards for the administration of new Foster Grandparent and Senior Companion programs. State agencies on aging and community action agencies are given 45 days in which to comment on grant proposals made by other applicants. Proposals from applicants other than State agenices on aging and community action agencies must contain assurances of coordination with these agencies. The comment and review period for State agencies on aging on applications for new RSVP programs, mandated by previous law, was reduced from 60 to 45 days.

---

[4] Public Law 94–478: Older American Volunteer programs are authorized under title II of the Domestic Volunteer Service Act of 1973, as amended. During 1978, provisions extending the authorizations of appropriations for these programs were passed by the House of Representatives as part of the Comprehensive Older Americans Act Amendments of 1978 (H.R. 12255). Similar provisions were passed by the Senate as part of the proposed Domestic Volunteer Service Act Amendments of 1978 (S. 2617). Final action was taken on the Older American Volunteer programs as part of the House-passed bill.

No final action was taken on the Domestic Volunteer Service Act Amendments of 1978 during the 95th Congress. The bills included provisions for other programs which may serve the elderly, such as VISTA (Volunteers in Service to America) and the proposed new Urban Neighborhood Volunteer programs. Two of the proposed new programs—Helping Hand and Fixed Income Counseling—would primarily assist older Americans. Controversy over other aspects of the proposed Urban Neighborhood Volunteer program, the absence of any congressional hearings on these proposals, and the crush of legislative activity in the last days of the 95th Congress contributed to no final action on S. 2617. Further action is expected in the 96th Congress.

Stipend increase for Foster Grandparents and Senior Companions.—Foster Grandparents and Senior Companions are usually provided with a small hourly stipend to help defray the expenses of their volunteer work. Volunteers work an average of 20 hours a week and are paid a stipend of about $1.60 an hour. This amount has not been increased since the inception of the programs. Public Law 95–478 authorized a stipend increase to $2 an hour. The law conditions any increase, however, on an appropriation of funds sufficient to maintain the number of volunteers serving in these programs during the prior fiscal year. Without a supplemental appropriations bill for fiscal year 1979, there will not be sufficient funds to implement the authorized stipend increase.

Broadened program eligibility for Foster Grandparents and Senior Companions.—Previous law restricted participation in the Foster Grandparent and Senior Companion programs to individuals age 60 and over who had incomes at or below the official poverty level.[5] In an effort to broaden these volunteer opportunities to more older Americans, Public Law 95–478 authorized participation by older Americans with incomes up to 125 percent of the official poverty level. Preference is retained, however, for those with the lowest income.

Reaffirmation of volunteer goals of RSVP.—Concern was expressed by spokesmen for the ACTION agency during reauthorization hearings that many retired senior volunteers were participating in programs which did not reflect areas of basic human needs. Testimony revealed an equal concern on the part of program participants that a change in program direction would tend to limit participation to low-income and minority elderly.[6] Public Law 95–478 includes language stipulating that RSVP volunteers are not "employees" for any purpose which the Director of the ACTION agency finds not to be fully consistent with the provisions and purposes of the Domestic Volunteer Services Act. The conference report accompanying the reauthorization bill reaffirms the intent of Congress that it is "not appropriate" to apply a means test for volunteers participating in the RSVP program.[7]

D. A TRANSFER TO THE ADMINISTRATION ON AGING?

On February 28, 1978, Senators Domenici, Percy, and Brooke, of this committee, and Senators Dole, Schmidt, Bellmon, and Hatfield introduced S. 2609, a bill to extend and expand the Older Americans Act of 1965. S. 2609 contained a provision which would have transferred the OAVP from the ACTION agency to the Administration on Aging, effective September 30, 1978.

---

[5] Title II of the Domestic Volunteer Service Act of 1973, as amended.

[6] Hearings before the Senate Subcommittee on Child and Human Development, "Domestic Volunteer Services Act Extension of 1978," Feb. 9, and 20, 1978. See also hearings on "The Older Americans Act of 1978," before the Senate Subcommittee on Aging, Feb. 1, 3, 7, and 8, and Apr. 21, 1978; and hearings before the House Subcommittee on Select Education, "Oversight on the Age Discrimination Act of 1975 and Extension of the Older Americans Act of 1965," Mar. 6, 13, and 20, 1978.

[7] House of Representatives, Report No. 95–1618, 95th Congress, 2d session, "Comprehensive Older Americans Act Amendments of 1978," conference report, Sept. 22, 1978.

During reauthorization hearings, major national aging organizations recommended that the Older American Volunteer programs be transferred to the Administration on Aging, stressing the importance of improved coordination of all programs serving the elderly. Testimony was also presented, however, from program directors and participants which stressed the advantages of retaining administrative authority within the ACTION agency.[8]

Public Law 95–478 retains administration of RSVP, Foster Grandparents, and Senior Companions within the ACTION agency through fiscal year 1981. Conferees conditioned this provision, however, on the results of oversight hearings to be conducted early in the 96th Congress by the Senate Subcommittee on Child and Human Development and the House Select Education Subcommittee. Hearings are to assess ACTION's commitment to the Older American Volunteer programs and determine whether or not to transfer these activities to the Administration on Aging.[9]

The President's reorganization project, within the Office of Management and Budget, is also considering a transfer of these ACTION programs to the Administration on Aging as part of a broader study of possible options for reorganizing a number of human service programs now scattered between 10 Federal departments and agencies. A recommendation is not expected until 1979.[10]

E. ADMINISTRATION FISCAL YEAR 1980 BUDGET REQUEST

The administrations budget request for fiscal year 1980 requested an increase of $3.1 million for the Retired Senior Volunteer Program, an increase of $1.1 million for the Senior Companion Program, and an increase of $5.8 million for the Foster Grandparent Program. The requested increases were to be used primarily for increases in volunteer stipends and administrative support, rather than program expansion.

II. COMMUNITY SERVICES ADMINISTRATION

Reauthorization of the Economic Opportunity Act of 1964, including a number of programs providing specialized services to the elderly, took place during 1978.

Programs of senior opportunities and services, community food and nutrition, emergency energy conservation and crisis intervention, and local initiative programs through community action agencies were reauthorized. Additional emphasis was placed on coordination with other Federal programs serving low-income elderly and on the expansion of community action agencies in rural areas.

A. REAUTHORIZATION OF ECONOMIC OPPORTUNITY ACT

Title II of the Economic Opportunity Amendments of 1978[11] extended the senior opportunities and services, community food and nutrition, emergency energy conservation, and community action agencies through fiscal year 1981. Funding levels for all title II programs were left to the discretion of the House and Senate Appropriations Committees. Appropriations for fiscal year 1979 were covered by a continuing resolution, based on fiscal year 1978 funding levels,[12] unless altered by a supplemental appropriations bill.

---

[8] Hearings cited in footnote 6. Additionally, correspondence to Senator Frank Church, chairman, Special Committee on Aging, from Betty Herrman, president, National Association of Retired Senior Volunteer Program Directors.

[9] Report cited in footnote 7.

[10] Staff working paper, Human Services Study, President's reorganization project, Executive Office of the President, Office of Management and Budget, July 1978.

[11] Public Law 95–568, signed by the President on Nov. 2, 1978.

[In millions of dollars]

	Fiscal year 1978 appropriations	Fiscal year 1979 administration budget request	Fiscal year 1979 appropriation [1]
SOS	10.5	10.5	10
CFNP	29.5	22.0	30
Energy:			
EEC [2]	65.0	10.0	65
ECI	200.0		200

[1] Continuing resolution based on fiscal year 1978 funding levels, Public Law 95–482.

[2] Appropriations for fiscal year 1978 for emergency energy conservation activities ($65 million) were primarily for CSA's home weatherization activities. The low fiscal year 1979 budget request ($10 million) reflects a shift in all programs of home insulation and weatherization from CSA to the new Department of Energy. Authorization of DOE weatherization activities retained the emphasis on low-income elderly and handicapped, however, and increased funding was provided for an expanded national effort to insulate homes. (See "Developments in Aging: 1977", part 1, Senate Report 95–771, p. 47, and p. 165 of this report for further discussion of DOE weatherization authorization.) Even though the operational authority for weatherization activities was shifted to the Department of Energy, Congress retained a similar authorization for the Community Services Administration in order to preserve the emergency nature of the program. The full $65 million appropriation for fiscal year 1979, based on the continuing resolution, however, may not be fully utilized for weatherization activities in recognition of DOE activities in this area.

SENIOR OPPORTUNITIES AND SERVICES [13]

The Senior Opportunities and Services program, administered by the Community Services Administration, was designed to provide services to low-income elderly, primarily to individuals not being served by other Federal programs for the elderly. SOS also gives preference to the employment of low-income elderly as service providers.

During 1978, approximately 1 million elderly were served by SOS through transportation, outreach, and advocacy activities. In addition, the programs provided support to a number of statewide elderly advocacy organizations.

Reflecting increasing concern for more efficient coordination between the SOS program and other Federal social service programs for the elderly, the 1978 amendments added new language to require that SOS program, when feasible, utilize the direct services of other agencies serving the elderly poor.[14]

COMMUNITY FOOD AND NUTRITION

The community food and nutrition program serves as the base for programs of congregate meals, home-delivered meals, nutrition counseling, and food stamp outreach and assistance activities. Although CFNP services are available to all low-income individuals, a primary emphasis has traditionally been given to low-income elderly.

---

[12] Public Law 95–482, signed by the President on Oct. 18, 1978.

[13] See "Developments in Aging: 1978," part 2, for a more detailed report on SOS program activities during the year.

[14] Public law cited in footnote 11. See also House of Representatives, Report No. 95–1766 conference report, Economic Opportunity Amendments of 1978, Oct. 11, 1978.

Previous law had limited administration of the CFN program to local community action agencies. The 1978 amendments, however, also made public and private, nonprofit agencies eligible for program grants.[15]

COMMUNITY ACTION AGENCIES

Approximately 875 community action agencies provide a wide range of services to low-income individuals, including low-income elderly.

The 1978 amendments took a number of steps to strengthen and expand community action agency services in rural areas:[16]

—Removed a prior prohibition against establishment of a community action agency to serve a geographic area with a total population of less than 50,000;

—Authorized $15 million over 3 years for special poverty programs in rural areas; and

—Increased the Federal matching share for community action agencies from 60 percent to 80 percent.

B. ENERGY CRISIS INTERVENTION—A CONFUSING HISTORY

During the past 3 years, the Community Service Administration's programs of emergency energy assistance and weatherization of homes for low-income individuals have undergone considerable change. The program, authorized under section 222 of the Economic Opportunity Act of 1964, as amended, provides funds for weatherization of homes of low-income individuals, with priority given to low-income elderly and disabled. Authority is also provided for a portion of these funds to be used to help pay utility bills or purchase fuel for home heating in emergency situations, although most of the energy program appropriation had been used for the weatherization program. In 1978, however, weatherization activities were shifted into the new Department of Energy and CSA placed increased emphasis on crisis intervention and emergency payment of home heating bills.[17]

An exceptionally cold winter during 1976 and 1977, coupled with drastic increases in the cost of home heating fuels, prompted Congress to make a special appropriation of $200 million to be used for energy crisis intervention.[18] The funds were allocated to States according to a formula which took into account the number of low-income households in the State, the relative severity of the winter, and the relative costs of heating fuels. An additional factor was included to give special emphasis on distribution of funds to the low-income elderly. Funds were distributed to individuals with incomes at or below 125 percent of the official poverty level who could not meet payments on outstanding bills for home heating or who needed cash assistance to continue delivery of home heating fuels. The program set a maximum amount of cash assistance at $250 per household and payments went directly to utility companies and fuel suppliers. Approximately 2.6 million people received this aid during the winter of 1976–77.

---

[15] Public law cited in footnote 11.

[16] Public law cited in footnote 11.

[17] Public Law 95-617 through Public Law 95-621 authorized transfer of home insulation programs to the Department of Energy. See footnote 2 of preceding table for detail.

[18] Public Law 95-26, Supplemental appropriations, fiscal year 1977.

A second severe winter, during 1977–78, led to a congressional appropriation of $200 million during fiscal year 1978.[19] For the second year, distribution of funds was limited to States in which the Director of the Community Services Administration designated an emergency situation and further emphasis was placed on providing assistance to low-income elderly. Individuals aged 60 and over with incomes at or below 150 percent of the official poverty level were eligible for assistance, as well as all elderly who participated in the supplemental security income program. Inability to pay outstanding home fuel bills was an additional eligibility criterion.

The supplemental appropriations bill making the second $200 million available for energy crisis intervention was not finally approved until March 1978, and the measure specified that all funds were to be distributed by May 1, 1978.[20] Even though the distribution period was only about 1 month, approximately $150 million was distributed to 2.7 million low-income individuals to pay delinquent fuel bills from the winter.

A court order subsequently extended the cutoff date for distribution of the fiscal year 1978 funds through March 1979. The funds remaining from the 1978 appropriation will be distributed to applicants eligible under the same 1978 guidelines.

For fiscal year 1979, the continuing resolution passed by Congress means that $200 million for energy crisis intervention will be made available during the winter of 1978–79. This is the third time that this funding amount has been provided.[21] Distribution guidelines have again been changed.

The future of the energy crisis intervention program is, at best, uncertain. The temporary, and emergency, nature of the program has caused delay, administrative problems, and congressional criticism.[22] Continuing threats to health and life in this and subsequent winters, however, have encouraged program extension.

---

[19] Public Law 95-240, March 1978; supplemental appropriations, fiscal year 1978.

[20] Public law cited in footnote 19.

[21] Public law cited in footnote 12.

[22] See "Developments in Aging: 1977," part 1, for discussion of criticism.

CHAPTER IX

NEW INITIATIVES ON HOUSING AND COMMUNITY ISSUES

Adequate and affordable housing in safe and supportive neighborhoods is a primary need of America's elderly. A Department of Housing and Urban Development study [1] released in mid-1978 provided new data about the housing characteristics and problems of older households. That study, based upon the 1975 housing survey, reported:

—The elderly, who now represent 11 percent of the population, comprised 20 percent of all households—homeowners and renters. More than 14 million households were headed by elderly individuals, 65 years or older, while only 5 percent of all older Americans lived in institutions.

—Homeownership is widespread, with 70 percent of all older heads of households, and 82 percent of all elderly married couples, residing in their own homes. Nationally, the elderly comprise 21 percent of all homeowners and 17 percent of renters.

—Most of the 3.3 million elderly poor in 1975 owned their homes—1.9 million—while 1.4 million were renters. The elderly comprise a disproportionate share of all poor households.

—The housing occupied by the elderly is older, cheaper, and of slightly lesser quality than that occupied by younger households. Close to 1 million elderly resided in units falling below HUD's minimum standards.

—HUD considers a housing unit to fall within this category if it has at least two of the following four deficiencies: (1) Lack of adequate indoor plumbing and a complete kitchen, (2) overcrowding, this is almost nonexistent for elderly households, (3) structural problems and unreliable heating, plumbing, and electrical systems, and (4) location in an environment having excessive crime, trash and litter, noise, and blight problems, or lacking access to transit, shopping, and health services.

—In general, the elderly have lower out-of-pocket expenses for housing than younger persons. The absence of mortgage indebtedness makes this particularly true for older homeowners, as 51 percent of them own, free and clear, a house valued at more than $25,000.

—For many elderly, however, housing costs are a burden. About 1.1 million older homeowners with incomes under $5,000 devote more than 35 percent of income to shelter. Elderly women renters are particularly hard hit, with 56 percent paying more than 35 percent of income for rental units. *In total, about 2.8 million elderly households*—1.1 million owners and 1.7 million renters—*pay ex-*

---

[1] "Housing Options for the Elderly," by Irving Welfeld and Raymond J. Struyk, HUD Office of Policy Development and Research, July 1978. Statistics on housing characteristics taken from pp. 18–38.

cessive (more than 35 percent) portions of their income for housing. Additional elderly households, while paying less, reside in the poorest quality housing.

During 1978, the Committee on Aging initiated a new series of hearings on neighborhood issues to examine the forces which place new pressures on older households and to study new methods, aside from traditional Federal housing programs, successfully to address the shelter needs of the elderly. The summary of a recent national symposium on "Community Housing Choices" provided compelling reasons to launch this study.

> Our country has devoted a large proportion of its effort in the area of housing to planned, clustered housing. The results have on the whole been deemed successful by experts, research workers, and users; perhaps 700,000 older people are currently being served by these efforts. The 20 million who are neither in institutions nor in planned housing have been far less well served. New construction of planned units can never accommodate the demand for improved housing among those willing to move. Even if enough new planned units were built, evidence is very strong that the majority of older people will sacrifice much to remain in a familiar neighborhood, to spin out their lives in a home to which they are symbolically and affectively attached, or to avoid the perceived stress of change. Currently, planned housing in its usual age-segregated form meets the needs of a substantial number of elderly, but the majority prefer continued residence in "normal" communities. Because of this majority's preferences, it is clearly time for our previous disproportionate emphasis on planned housing for the elderly to become balanced with proportionate concern for those who wish to maintain their lifestyle in ordinary communities.[2]

The 1978 Housing Act included two new neighborhood-oriented initiatives, reauthorized other programs of benefit to older households, and established a new congregate services program for the frail elderly residents of federally assisted housing. The Committee on Aging, in other actions, issued a new report on the problems of elderly residents of single-room occupancy (SRO) facilities, and held field hearings focusing on the problems encountered by retirees choosing condominium residences. The Federal Home Loan Bank Board also authorized the availability of a new mortgage instrument which can provide older homeowners with a new source of income based on their accumulated home equity.

I. THE 1978 HOUSING ACT

The Housing and Community Development Amendments of 1978[3] contain many provisions which should be of assistance to elderly households and their neighborhoods. They include:

Section 312 rehabilitation loans.—An authorization of $245 million is provided for the continuation of this low-interest loan program.

---

[2] "Community Housing Choices for the Elderly: An Early Summary of Program and Policy Suggestions," Philadelphia Geriatric Center, May 1978, pp. 3-4.

[3] Public Law 95-557, enacted Oct. 31, 1978.

Low- and moderate-income owner-occupants, and low- and moderate-income tenants in multifamily housing are to be the primary beneficiaries of the section 312 program. Interest for loans may rise above 3 percent when extended to households earning more than 80 percent of area median income.

Urban development action grants.—In selecting applicants for this innovative urban upgrading portion of the community development block grant program, the Secretary must now evaluate the impact of the proposed UDAG project on the low- and moderate-income tenants of the target neighborhood.

Financial assistance to troubled housing projects.—In order to promote the fiscal soundness and improve the management of federally assisted public housing projects, $74 million is authorized for operating subsidies in fiscal 1979.

Section 202 housing.—New language requires that the governing board of any nonprofit corporation assisted under this low-interest loan program for elderly and handicapped housing must be selected to assure significant representation of community views. This provision, while intended to increase the involvement of local residents in the development and operation of section 202 projects, will not preclude the participation of national nonprofit organizations in the program.

Public housing security demonstrations.—In response to the threats to life and property afflicting low-income and elderly tenants of public housing, $12 million is authorized for demonstration projects, during fiscal 1979, for the development and evaluation of anticrime methods for such projects and their surrounding neighborhoods. In order to derive maximum benefit from this new program, preference will be given to proposals stressing coordination with other Federal agencies. The HUD Secretary is required to report to the Congress on the results of the program within 18 months after enactment, and to make appropriate legislative recommendations.

Homeownership expansion demonstration.—The Secretary is authorized to undertake demonstrations to determine the feasibility of expanding homeownership opportunities in urban areas through the conversion of multifamily buildings to condominiums and cooperatives.

Rural rehabilitation assistance.—The section 504 program of low-interest rehabilitation loans to rural households received an authorization of $48 million for fiscal 1979.

Congregate housing services.—Title IV of the bill, the Congregate Housing Services Act of 1978, establishes a new program of services for frail elderly and younger handicapped residents of public and section 202 housing, in order to promote independence and prevent unnecessary institutionalization. The full history and provisions of this title are set forth later in this chapter.

Neighborhood Reinvestment Corporation.—Title VI of the act establishes the Neighborhood Reinvestment Corporation to carry on the innovative neighborhood conservation programs of the urban reinvestment task force through the neighborhood housing services (NHS) program. An authorization of $12.5 million is set for fiscal 1979.

Neighborhood self-help development.—A new program of grants and assistance for qualified nonprofit neighborhood organizations is established by title VII of the act, to assist with housing and revitalization projects in low- and moderate-income neighborhoods. Authorizations of $15 million each were set for fiscal years 1979 and 1980.

Livable cities.—Title VIII of the bill contains another new program for neighborhood organizations. Authorizations of $5 million for fiscal 1979, and $10 million for 1980, are provided for projects having substantial artistic, cultural, and design merits which can help to revitalize communities and enhance civic identity and pride.

Displacement study.—The Housing Act declares that the Federal Government, in its housing and community development programs, should minimize the involuntary displacement of people from their homes and neighborhoods. In addition, the HUD secretary is required to undertake a study on the nature and extent of the displacement problem, and to report her findings to Congress by January 31, 1979, along with recommendations for the formulation of a national policy to minimize displacement due to both public and private development.

In sum, the Housing and Community Development Amendments of 1978 evidence an increasing Federal concern about the stabilization and revitalization of neighborhoods, and a commitment—through the reauthorization and expansion of existing programs, and the creation of new tools—to facilitate these goals while minimizing the adverse effects for low and moderate income residents.

II. CONGREGATE HOUSING SERVICES

As noted, title IV of the 1978 housing act—the "Congregate Housing Services Act of 1978"—provides assistance for meals, housekeeping assistance, and personal care for disabled or frail elderly and younger handicapped residents of public housing and section 202 projects. The title is largely based on legislation introduced on March 8, 1978, by Senator Harrison A. Williams, Jr., Senator Frank Church,[4] and Senator Pete V. Domenici. Senator Church stated:

> This bill is but one part of the emerging strategy . . . for the extension of services to the frail elderly to help keep such persons in their homes and out of nursing homes and other institutions.
>
> The need for such innovative and effective means is great now and will continue to grow . . . between now and the year 2000, the number of Americans between 65 and 75 will increase by 23 percent, but the number who are between 75 and 85 will increase by 57 percent . . . it is precisely this segment of the elderly which is likely to need some assistance to maintain independent lives within their own residences. Without this assistance, they are likely to be institutionalized unnecessarily and prematurely, at great psychological harm to them and great expense to the government. . . .
>
> The Federal share alone for the annual maintenance of a low-income elderly person in a nursing home currently stands

---

[4] Additional Committee on Aging members cosponsoring at introduction were Senators Lawton Chiles, Edward Brooke, Dennis DeConcini, and John Glenn. On July 20, 1978, during Senate debate on the 1978 housing act, Ranking Minority Member Domenici introduced an amendment, which was adopted, adding section 202 housing as eligible for congregate services. Additional Committee on Aging cosponsors of the amendment were Senators Church, Chiles, Brooke, Percy, and DeConcini.

> at $5,500 under the medicaid program. In contrast, by subsidizing the difference between the cost of supportive services and the ability of elderly . . . residents to pay for them, this bill can sustain independence at a cost of approximately $1,000 annually.
>
> The Congregate Housing Services Act will finally implement housing law enacted in 1970 by providing a missing element—the availability of long-term financing for comprehensive service packages. . . . Hearings held by the Special Committee on Aging in 1975 revealed that only a handful of congregate public housing facilities had been established across America. That situtation remains unchanged today.[5]

Senator Domenici, ranking minority member of the committee, introduced an amendment which authorized congregate services for section 202 housing participants. Senator Domenici stated:

> HUD programs could be instrumental in meeting the spectrum of needs of the elderly if they were broadened to incorporate basic congregate services in housing serving the elderly. Presently, the section 202 program, while intended to specifically serve the elderly and handicapped, falls far short of its potential.
>
> We must consider the needs of elderly and handicapped persons residing in section 202 funded projects. In order for these individuals to remain in their homes and continue to live as independently as possible, it is necessary that they be provided with supportive services consistent with their needs. For the program to be a truly effective governmental effort, it is important that congregate services be available within the context of the program.

Hearings, chaired by Senator Williams, were conducted in the Senate Subcommittee on Housing and Urban Affairs on April 13, 1978. Strong support for the legislation was voiced by gerontology specialists, national aging organizations, and housing officials.[6] John Martin, testifying on behalf of the American Association of Retired Persons/National Retired Teachers Association, stated:

> Every test we've made shows that older people do not want to go to nursing homes unless there is absolutely no alternative. . . . The National Housing Act of 1970, which led in the direction of congregate housing, produced no results. . . . The result has been that there has been a steady drift into nursing homes, largely because there were no alternative services. . . . S. 2691 appears to us to be a very good and innovative approach to this whole problem.

A spokesman for the National Association of Housing and Redevelopment Officials characterized the bill as "equal in importance to the pioneering legislative provisions of 1956 which first authorized the admission of single elderly persons into public housing." And Perfecto Villarreal, executive director of the San Antonio, Tex., Housing Authority, provided a special perspective on the need for the legislation:

---

[5] Congressional Record, Mar. 8, 1978, p. S3256.

[6] "Strong Support for the Congregate Housing Services Act," a statement by Committee Chairman Frank Church summarizing the testimony presented at the hearing, appears in the May 1 Congressional Record at p. S6616.

> The two primary reasons for our people moving out of housing for the elderly is either because they die, or they are forced to move to a nursing home. . . . The cost in both human and monetary terms of not taking action to stem this tide of elderly evictions is too great . . . in San Antonio, the nursing home expense varies from $25 to $50 per day . . . many elderly persons are forced to live in San Antonio State Hospital because there is no housing available which provides a basic package of support services. The average daily cost for caring for a person in the State hospital is $59. . . . I estimate that providing a good basic package of supporting services in San Antonio would cost from $2 to $5 a day. . . . The monetary savings of a congregate housing program to the taxpayer would be very, very substantial.

As enacted, the Congregate Housing Services Act contains the following major provisions:

—The HUD Secretary is authorized to enter into 3- to 5-year contracts with public housing authorities and nonprofit section 202 sponsors for the provision of congregate services.

—Applicants are required to afford local area agencies on aging an opportunity to participate in the determination of the means of providing services, and to review and comment upon applications for funding prior to their submission to HUD. This provision is meant to encourage the coordination of housing and human service programs at the local level.

—Eligibility of residents for appropriate services will be determined by a professional assessment committee including qualified medical experts.

—The HUD Secretary is required to submit an annual report to the Congress evaluating the impact and effectiveness of assisted congregate services programs.

—New employment opportunities are provided for elderly project residents to participate in the provision of assisted congregate services.

—A 4-year authorization is provided: $20 million for fiscal 1979, $25 million for 1980, $35 million for 1981, and $40 million for 1982.

The Congress made an initial appropriation of $10 million to implement the congregate services program in 1979. HUD anticipates that guidelines for the program will be finalized by the spring of 1979, and applications will be processed and selected for funding by the end of the summer. This initial appropriation will provide approximately $1.8 million annually for 5-year service contracts; the act requires that 10 percent—$1 million—be held in reserve for supplementary adjustments. HUD estimates that from 50 to 75 demonstration projects can be initiated at this funding level.

III. INQUIRIES INTO CHANGING NEIGHBORHOOD DYNAMICS

The 1978 housing act's increasing emphasis on programs which assist in revitalizing neighborhoods and rehabilitating existing housing stock acknowledges that the housing and community needs of Americans cannot be met by new construction alone. This is particularly true for older Americans, because 70 percent of all elderly households own their own homes and need assistance primarily in the areas of maintenance, and financial relief from rising property taxes and utility bills. A November 1978 report on "Neighborhood Conservation and the Elderly,"[7] funded by the Administration on Aging, found that most elderly prefer a home in a familiar neighborhood—even a deteriorating neighborhood—to a new unit in unfamiliar surroundings. The trauma which accompanies the involuntary displacement of older individuals is of such a high degree as to merit consideration of special treatment for older residents confronting increasing housing pressures.

In December 1978, the Committee on Aging began a new series of hearings on "Older Americans in the Nation's Neighborhoods." Senator Dennis DeConcini, who presided at the opening inquiries in Washington, D.C., and Oakland, Calif., outlined the committee's interest in this area:

> Federal and private urban renewal efforts are having positive effects in many neighborhoods of this Nation. These new signs of city renaissance are welcome, but redevelopment activities can create new problems for existing neighborhood residents—and particularly for elderly homeowners and renters, who are least able to adjust to forced relocation or to cope with rising rents, property taxes, and maintenance costs.
>
> Mr. Rolf Goetze, director of housing revitalization at the Boston Redevelopment Authority, sums up the peril and promise of the new neighborhood efforts in a recent report prepared for the Department of Housing and Urban Development (HUD), "Stabilizing Neighborhoods: A Fresh Approach to Housing Dynamics and Perceptions." He states:
>
> "Most know of the baby bulge, the large number of children born between 1940 and 1965 . . . At each turn, accommodating this bulge has strained the system.
>
> "But even more drama is in store for the period from 1975 to the year 2000, because during this period 16 percent more than normal will seek to come to roost. The stresses this will cause are hard to visualize in advance. Those who have spent the last twenty years fighting blight will be unprepared.
>
> "When the tidal move of new households engulfs urban areas, most of the existing housing supply will be brought into place because the Nation simply cannot produce enough housing in the next fifteen or twenty years to meet the new demand.
>
> "For policymakers, the implications should be clear. The last twenty years can be characterized as the period when problems of urban blight caused special stress; and the com-

---

[7] This report, authored by Senior Associate Phyllis Myers, is available from the Conservation Foundation, 1717 Massachusetts Avenue N.W., Washington, D.C. 20036.

> ing twenty years as the period of rediscovery, speculation, and dislocation. Lest we confuse this with the Biblical image of lean years followed by years of plenty, we must realize that coming events can bring with them a full measure of trauma, particularly for existing residents.
>
> "Revitalizing neighborhoods offer an unprecedented opportunity to maintain diversity if appropriate public policies are pursued . . . public policies must actively foster a better partnership with the residents and the private sector."
>
> Shortcomings in available data leave us unable to accurately gage the nationwide extent of neighborhood revitalization activities and their long-term prospects, but growing anecdotal evidence suggests that such activity is on the rise nationwide. The National Urban Coalition's August 1978 report, "Displacement: City Neighborhoods in Transition," said its 44-city survey showed:
>
> "A combination of circumstances . . . has created an uneven but definite inmigration of middle-class homeowners and renters who are taking up residence in city neighborhoods that they and financial institutions once shunned. . . . The benefits of a strengthened tax base and of some gains in residential and commercial revitalization are clashing with the deprivation, frustration and anger of those who are becoming the new urban nomads. . . .
>
> "The elderly are the most often displaced." [8]

Senator DeConcini also observed that the same features which make neighborhoods attractive to newcomers—public transit, close proximity to stores and services, and special local character—make them excellent locales for residence by the elderly. He noted that "rethinking is also needed in the public and private sector if market dynamics are to benefit whole cities rather than select areas."

In his opening statement at the Washington hearing, the Senator noted: "healthy neighborhoods are a prerequisite for healthy cities . . . at a time when renewed interest, and new capital, is conserving the physical resources of neighborhoods, equal attention must be paid to their human resources." Declaring that the implications of new reports of shifting urban investment patterns and ensuing displacement "are more than academic matters for older Americans," he continued:

> More than half of America's elderly reside in urbanized areas; a full one-third reside in central cities.
>
> For the 7 out of 10 older Americans who own their own home, will these changes bring enhanced equity, better municipal services, and lowered crime on the streets?
>
> Or will it bring agonizing choices as speculation results in skyrocketing property taxes, or even in displacement as code enforcement is stiffened? For the 30 percent of the elderly who rent, will escalating prices or condominium conversions force them out of long-occupied dwellings and into more affordable, but less desirable, parts of the city?

---

[8] "Saving the Cities: For Whom?"; statement of Senator Dennis DeConcini Congressional Record, Oct. 11, 1978, p. S18261.

> . . . How can we continue to maintain the diversity of age, economic status, and ethnic background that are drawing so many of the urban pioneers back into the hearts of our metropolitan area?

Witnesses at the opening hearing generally concurred on the following key points:

—Altered urban dynamics and long-term demographic and economic trends were resulting in increased displacement of low-income persons, particularly the elderly. However, much more data is required to fully gage the extent of this problem and its specific impact on older individuals.

—Reinvestment in urban neighborhoods can have positive effects for cities and elderly residents. But both public policy and market perceptions must change if benefits are to be spread and speculation is to be discouraged.

—The aging network established under the Older Americans Act could play a vital role in assisting elderly residents through the coordination of rehabilitation assistance and other services promoting neighborhood revitalization.

—Successful efforts to stabilize and revitalize neighborhoods are most often developed by local government and community organizations. The Federal Government can best assist these efforts by refraining from massive programmatic responses, providing instead technical assistance and modest grants of funds.

—While HUD is shifting the emphasis of portions of its housing and community development programs to small-scale targeted activities, the most successful neighborhood assistance effort to date has been the Neighborhood Housing Services (NHS) program operated by the Urban Reinvestment Task Force (now transformed to the Neighborhood Reinvestment Corporation by title VI of the 1978 housing act). NHS has operated best in neighborhoods whose housing stock requires maintenance but is essentially sound. The program is based on the strong participation of residents, community groups, and representatives of municipal government and local financial institutions. The elderly have been most active in NHS, both as community proponents and assisted households. A high-risk revolving loan fund to meet the needs of residents, such as the elderly, who generally cannot meet commercial credit requirements; and the offering of rehabilitation counseling, construction monitoring, and related services, are the key ingredients of the NHS strategy.

CALIFORNIA TESTIMONY

A followup hearing in Oakland, Calif., focused on the particularly severe housing pressures in the San Francisco Bay area. In San Francisco, more than 17,000 elderly now reside in the crime-infested "Tenderloin," a downtown area whose low-priced hotels are also frequent arson targets. And, in Chinatown, real estate speculation fueled by foreign capital is replacing already insufficient housing stock and neighborhood businesses with stores and services for the tourist trade. A representative of the Chinatown Neighborhood Improvement Resource Center—recipient of a HUD grant for the study of means to improve housing conditions without creating massive displacement—testified that, although the neighborhood contains some of the most substandard housing in the United States, continued occupancy in this ethnic enclave is essential to the survival of Chinese elders.

I. Donald Terner, director of housing and community development for the State of California, testified that the combination of fixed incomes and rising shelter costs have produced a situation where more than two-thirds of the State's elderly now pay more than one-quarter of income for housing. He also noted that many landlords, fearing rent control initiatives in the wake of the successful passage of the "proposition 13" property tax reduction measure, were rushing to convert rental properties to condominiums. He cited a number of instances in which the trauma of forced moves due to conversions had resulted in physical deterioration or even death for older tenants.

The committee is considering a continuation of its "neighborhoods" hearings, including closer scrutiny of the condominium conversion issue, during 1979.

IV. REPORT ON SRO QUARTERS

In cities large and small across the Nation, single-room occupancy hotels (SRO's) provide low-cost shelter to tens of thousands of elderly. These facilities are often located in areas—such as San Francisco's "Tenderloin"—which offer good access to transit and social services, but also present many dangers.

In August 1978, this committee released an information paper [9] on these "invisible elderly" who occupy SRO's.

Committee on Aging Chairman Frank Church, and ranking minority member Pete Domenici, commented on differing characterizations which have been made of these older individuals:

> Some have painted SRO's as the final home on skid row for society's misfits, the transient loners and drifters who have not so much retired as have simply become cut off from even marginal employment. Others picture SRO's as a hospitable environment providing friendship, access to services, freedom, and a superior alternative to the nursing home for those who, for reasons often beyond their own control, have fallen to the bottom rungs of a society which cares little for the aged.

The paper presents a summary of what is known about SRO's and the Federal policies which affect them. Specific legislative recommendations for providing tools for upgrading SRO's, in order to provide a decent housing option in revitalized neighborhoods for those elderly who prefer this lifestyle, are being considered in the context of the committee's "Neighborhoods" hearing.

V. HEARINGS ON CONDOMINIUMS

While condominium conversions are creating problems for some elderly tenants, this form of residence has many attractions for older

---

[9] "Single Room Occupancy: A Need For National Concern," an information paper prepared for use by the Special Committee on Aging, June 1978.

Americans. In a time of rising housing prices, condominium ownership offers retirees a means of accumulating equity while maintaining relatively stable maintenance costs. Further, many condominiums offer amenities which would otherwise be beyond the means of older consumers.

While virtually unknown in the early sixties, there are now more than 2 million condominium units housing 5 million Americans—and many experts predict that condominiums will constitute at least half of all new housing construction by the mid-1980's. Older Americans and young marrieds have been the two demographic groups most attracted to this housing form.

The lack of uniform national standards for consumer protection and disclosure in condominium sales is a problem, however—particularly for those elderly who, upon retirement, move across State lines to senior communities. Committee on Aging member Lawton Chiles cosponsored "The Condominium Act of 1978," [10] legislation drafted by a special HUD task force designed to establish such minimum national safeguards, and to encourage States to enact stricter protections, while holding paperwork burdens for developers to a minimum. That bill did not receive hearings in either the House or Senate during the 95th Congress, but it will be reintroduced in the 96th, and prospects for Banking Committee consideration appear improved.

FLORIDA HEARINGS

In November 1978, the Committee on Aging held field hearings on "Condominiums and the Older Purchaser" in Hallandale and West Palm Beach, Fla. Senator Chiles, in his opening statement, outlined the advantages which condominiums could offer the elderly, the need for Federal standards, and the objectives of the hearings:

> Today's hearing on "Condominiums and the Older Purchaser" is undertaken in the belief that condominiums and other new forms of residence ownership will be chosen increasingly by the growing ranks of older Americans. Despite the problems which characterized the early years of Florida's condominium industry, the 1975 HUD condominium/cooperative study found that 96 percent of south Florida unit owners were either satisfied or very satisfied with the condominium lifestyle, and that more than 70 percent would again purchase a condominium if they could choose again. Clearly, condominium living can offer good housing, recreational opportunities, and a potential for community self-management and social interaction which is attractive to retirees, and well within the means of many. . . .
>
> Florida is in the forefront of condominium construction, and is unique in the percentage of retirees occupying those units. Florida now has one of the Nation's exemplary condominium laws. However, this body of law was not developed to forestall difficulties but came as a result of abusive practices, carried out by a destructive minority within the devel-

---

[10] S. 2919, introduced Apr. 13, 1978. Senator Chiles' remarks at introduction appear in the Congressional Record at pp. S5538–40.

> opment industry; at one point threatening not only the savings and well-being of purchasers, but the entire condominium industry. . . .
>
> In one specific area, the "Condominium Act of 1978" would offer substantial relief to tens of thousands of older Floridians who have been unduly victimized. This is in regard to the abusive practice of escalating, 99-year leases for recreation facilities. . . .
>
> These contractual arrangements are intolerables.
>
> Purchasers were unaware of them and had no power to negotiate and modify them.
>
> They extend far beyond the useful life of these recreational facilities and reimburse developers many times over for their costs.
>
> And, due to escalation clauses tied to the consumer price index, they threaten to rob elderly residents of their dignity and their life savings, and even to destroy the fiscal stability of the condominiums they occupy. . . .
>
> Today's hearing has a wider purpose beyond an examination of the need and specific form of Federal condominium legislation. We want to consider such questions as:
>
> How are retirees coping with the self-management responsibilities, often of enormous proportions, in multi-million-dollar projects?
>
> What effect is inflation having upon older residents who have retired on fixed incomes and anticipated relatively stable residential expenses as one of the chief benefits of condominium living?
>
> And, with the conversion of rental units to condominiums on the rise both in Florida and nationwide, is enough being done to protect the interest of both long-term renters and new purchasers?
>
> Finally, we will inquire into whether sufficient thought and planning is being directed to meeting the present and future needs of aging condominium populations.

Testimony received at the hearings indicated that the burden of long-term escalating recreation leases on residents of projects built prior to prohibitive State laws was the greatest burden and threat for affected elderly residents. Instances were cited of exorbitant returns to developers—in one instance, a facility which cost $200,000 to construct had returned more than $300,000 in fees in its first year of operation and, given an average inflation rate of 5 percent annually, could be expected to return $700 million to the developer over its 99-year term. Some unit owners associations are attempting to "buy out" their leases, but again face abuses—one developer is asking $31 million for a 10-year-old facility constructed at a cost of $750,000. Assistant Florida Attorney General Thomas Pflaum, assessing the future impact of these contractual arrangements on the accumulated equity of tens of thousands of retirees and the fiscal soundness of their residences, concluded:

> The economics of the situation are impossible. In the cases that I have handled, the rent under the leases has doubled,

> gone up 100 percent in 5 years, and it probably will do so again. That bubble is inconceivable, it simply can't continue to grow.

Other witnesses described additional problems which have afflicted older consumers, including shoddy construction, misuse of deposits, deliberate underestimating of monthly operating assessments, and incomprehensible legal documents. Rod Tennyson, a West Palm Beach attorney, cited the need for further investigation of the "company store concept," whereby developers reserve for themselves the exclusive right to provide insurance, cable television, management, vending and laundry machines, and garbage collection and exterminating services, through self-dealing contracts secured by liens on each condominium unit.

Withdrawal of services, or their absence, is an additional problem. Lucille Stang, a resident of Lauderdale Lakes, Fla., recalled how the availability of a courtesy transportation service played a major role in her decision to purchase her condominium. But, she recounted, "After the developer sold the last unit, they moved out the buses."

Nan Hutchinson, director of the Broward County Area Agency on Aging, testified that a lack of local planning and sufficient funds had resulted in thousands of elderly in outlying condominium developments being without adequate transit, social services, and commercial facilities.

These hearings, and continuing committee attention to the condominium issue, will be utilized to demonstrate, in Senator Chiles' words, that "uniform national standards and access to the Federal courts are essential if retirees moving to other States are not to suffer the same agonies that took place in Florida before adequate minimum State laws were enacted.[11]

VI. REVERSE MORTGAGES APPROVED

Although a majority of America's elderly own their own homes, traditional mortgage instruments and discriminatory lending practices have made it difficult or impossible for them to utilize this accumulated and appreciating equity as a source of additional income. In the past few years, a small number of State-chartered lending institutions have begun offering so-called "reverse annuity mortgages" (RAM's) which permit older homeowners to convert part of their home equity into a steady, reliable flow of income.

On June 12, 1978, Committee on Aging Chairman Frank Church wrote to Robert McKinney, Chairman of the Federal Home Loan Bank Board, to advise him "of the strong support which the reverse annuity mortgage concept has received from this committee's membership" and to urge that they be made available on a nationwide basis with adequate consumer safeguards. This action followed a statement made on the Senate floor by Chairman Church, in which he outlined the usefulness of this new mortgage instrument and the types of protections required:

> Most older Americans do not live in Government-aided housing but in the community at large. About 70 percent own

---

[11] Congressional Record, Jan. 29, 1979, p. S800.

171

> their own homes, which are generally free and clear of debt. The total equity they have built up in their dwellings is estimated to be at least $90 billion. Despite this illusion of wealth, older Americans are faced by shelter problems which may be building toward crisis proportions. Rising property tax assessments, higher fuel costs, expensive maintenance requirements, and general inflation, all combine to produce a need for additional income.
>
> Yet the elderly's "home equity" is usually unavailable to them unless they are willing to sell the homes they worked so hard to buy. Persons over 65 cannot obtain a 20- or 30-year traditional second mortgage. The only options open to many older homeowners are forced sale, doing without necessities, or forgoing home maintenance.
>
> This need not be the case. The Federal Home Loan Bank Board (FHLBB) has extensively studied a proposed new mortgage instrument, known as the reverse annuity mortgage (RAM). RAM's permit the older homeowner to convert part or all of his home equity into a series of monthly payments. Certain types of RAM's also provide insurance against the outliving of one's resources. In effect, the operation of a RAM is like a normal annuity, with a savings and loan institution making a loan, secured by the home, to purchase the annuity. The annuitant's estate would be responsible for settling that debt in probate.
>
> RAM's have been available in England for over a decade, and are permitted in other European nations. It is high time that this means of helping the elderly to help themselves—and of redressing the discrimination they currently face in the mortgage market—be authorized in the United States. FHLBB's studies reached the conclusions that RAM's "can provide a fundamental financial service of major social significance," "are entirely feasible," and face complications "of form rather than substance."
>
> . . . The FHLBB should be required to approve and regulate RAM's under statutory language specifically assuring adequate safeguards for older homeowners. In particular, sufficient and understandable information must be furnished to the prospective purchaser, and interest must be calculated in a reasonable manner.[12]

In August 1978, the Senate Committee on Banking, Housing, and Urban Affairs held hearings on several new mortgage instruments proposed for availability by the FHLBB, including RAM's. Chairman McKinney testified:

> For older homeowners with substantial equity who are looking to supplement their monthly incomes, the reverse annuity mortgage would be attractive. . . . In principle, a RAM may be tailored to fit almost any individual's objectives or needs . . . the homeowner retains the same rights of ownership, use, and possession as any other mortgagor. The equity retained . . . allows the homeowner to enjoy any

---

[12] Congressional Record, May 18, 1978, p. S7767.

> increases in the property's value, encourages maintenance of the property, and may be used for bequests at death.

However, he concluded:

> As a general rule, RAM's could be expected to entail more careful counseling and planning and occasionally much more involved calculations than any other form of mortgage if the best buy is to be obtained for the homeowner.

On December 14, 1978, the FHLBB authorized the more than 2,000 Federal savings and loan associations to begin offering a number of new mortgage instruments, including RAM's. Because of the wide variety of forms which RAM's can take, the FHLBB will approve associations' applications to offer this financial service on a case-by-case basis. However, in all instances, consumers must receive full disclosure of the terms and costs of the mortgage; the interest rate for the entire term of the RAM must be fixed; and the homeowner retains the right to refinance the RAM at its expiration.

CHAPTER X

TRANSPORTATION: SLOW PROGRESS TOWARD BETTER MOBILITY

Adequate, appropriate, and affordable transportation remains a continuing need for many older Americans. Diminished physical abilities, combined with the ever-increasing costs of maintaining a private automobile, cause many elderly persons to forsake driving as their principal mode of transit. At the same time, improved transportation services are needed if the elderly are to continue to live independently and have access to suitable social services programs.

During 1978, a major step was taken to continue and improve Federal support for public transportation with the enactment of a comprehensive reauthorization of highway and mass transit programs. Questions concerning the implementation of the "Transbus mandate" were resolved, assuring that full-sized buses purchased in the future with Federal assistance would be fully accessible to the elderly and handicapped. However, debate on the accessibility issue shifted to the means by which the Department of Transportation will comply with section 504 of the Rehabilitation Act.

Insurance costs and accessibility problems for special transportation services—which were brought to public attention by 1977 Senate Committee on Aging hearings—seemed closer to resolution as a White House task force joined the search for solutions. Legislation setting Federal no-fault auto insurance requirements, however, was deferred.

I. THE NEW FEDERAL TRANSPORTATION BILL

Faced with ever-increasing usage of mass transit [1] and a growing need for new funds to maintain and improve these services, the Congress passed, in 1978, a combined transit and highway bill [2] which authorized $16.4 billion in public transportation aid for fiscal years 1979–83.

A. Senate Action

The Senate, in developing new transit legislation, adopted a modified version of the bill advanced by the administration: the Federal Public Transportation Act of 1978 (S. 2441). This bill strengthened transportation planning and encouraged improved coordination of highway and transit programs, simplified funding categories while permitting recipients to exercise greater flexibility in the use of assistance, and established a predictable funding mechanism for routine captial and operating needs.

---

[1] The Senate Committee on Banking, Housing and Urban Affairs, in its report on the Federal Public Transportation Act of 1978, noted: "Since 1973, total ridership has increased by almost half a billion riders annually, accounting for a 10-percent increase over that period." S. Rept. 95–857, p. 4. More recent figures indicate a continuation of that trend, with ridership for the first 10 months of the 1978 up 5.5 percent over the total for the same period in 1977; New York Times, Dec. 19, 1978, p. D22.

[2] H.R. 11733, Public Law 95–599, enacted Nov. 6, 1978.

In addition, a new formula grant program for small urban and rural areas was attached to the bill to foster more effective transit services in these areas. The report of the Committee on Banking, Housing, and Urban Affairs explained:

> . . . a program of capital assistance alone for these areas was insufficient to encourage the development or improvement of public transportation services. Without the availability of operating assistance, few communities were interested in applying for vehicles that the communities could not afford to operate. . . . The committee believes that a separate program can be particularly effective in focusing both Federal and local attention on the need to promote public transportation in small urban and rural areas. . . . The committee wishes to stress the need for the development of coordinated transportation programs in these areas. Many programs sponsored by different Federal agencies . . . provide transportation services to meet various social service and other needs. Coordination of these services, especially in rural areas, will provide a much more effective network of transportation services. Also, a reasonable portion of funds apportioned under this program should be used to promote the development of appropriate public transportation services on or serving Indian reservations.[3]

The Senate bill also ended the separate permissive set-aside for special transportation services for the elderly and handicapped—the so-called 16(b)(2) program. However, the committee report emphasized that such activities would continue to be eligible for funding from the urban formula grant program; that it was intended that the Secretary of Transportation issue guidelines to insure that the 16(b)(2) program continue as a distinct and adequately funded program;[4] and that such special services would be eligible for funding, including operating expenses, under the new rural and small urban funding program.[5]

B. Revisions in Conference

Title III of the Surface Transportation Assistance Act of 1978, the highway-transit bill agreed to by House and Senate conferees, substantially restructures and simplifies the funding mechanisms for mass transportation services, although not in as sweeping a manner as set out in the Senate version.

---

[3] S. Rept. 95-857, p. 25. Administration on Aging Information Memorandum No. 78-30, transmitted to State agencies administering Older Americans Act programs on Apr. 7, 1978, advised them of General Accounting Office suggestions for improving the coordination of special transportation services.

[4] Early in 1978, in order to assess the effect of the administration transit proposal upon services for the elderly and to assure that 16(b)(2) activities would not be diminished under the revisions Committee on Aging Chairman Frank Church and Ranking Minority Member Pete Domenici dispatched a number of questions to Transportation Secretary Brock Adams. That text and the Secretary's reply, are contained at pp. 267-71 of "Developments in Aging: 1977."

[5] During Senate debate on S. 2441, Committee on Aging Chairman Frank Church and Senator Harrison A. Williams, Jr., engaged in a colloquy concerning the effect of the reauthorization bill on the transit needs of the elderly. Congressional Record, Sept. 28, 1978, pp. S16410-412. The Senators agreed that adequate levels of support for special and rural transit programs were a continuing necessity.

The Senate action terminating the separate set-aside for 16(b)(2) special transit activities was deleted by the conferees. Instead, these services will continue to be funded at a level of up to 2 percent of the discretionary grant program; providing potential levels of assistance of $27.5 million in fiscal 1979, rising to $32 million in fiscal 1982, for the capital purchase costs of special transit vehicles.

For rural and small urban areas, the conferees agreed to a new formula grant program for the development and support of coordinated transit services. Report language specifies that Indian reservations should receive a fair and equitable portion of funding; that eligible recipients include public bodies and nonprofit organizations; and that the Transportation Secretary should develop simplified regulations which facilitate rapid rural transit development with a minimum of redtape. Authorization levels for the new program start at $90 million in fiscal 1979, and rise to $105 million in fiscal 1982.

The Federal commitment to expanded and coordinated public transportation services in both urban and rural areas, exhibited in this reauthorization legislation, should help to better meet the needs of America's elderly. However, while the 16(b)(2) capital purchase program was continued at increased funding levels, questions persist as to the availability and adequacy of operating funds for such special transportation.

Further revision of Federal transportation aid is possible during the 96th Congress: Secretary Adams has indicated that he would like to consolidate the separate highway and mass transit programs within a reorganized Department of Transportation. It is not yet clear whether this goal will be achieved through legislation or an executive reorganization.[6]

II. THE ISSUE OF BARRIER-FREE ACCESS

Because many older persons suffer from physical limitations,[7] it is important to them that public transportation vehicles and facilities be designed in a manner which facilitates their use. During 1978, a compromise was reached concerning Secretary Adams' ruling of the prior year that, in the future, all full-sized buses purchased with Federal aid must be of the barrier-free low-floor transbus design. However, a new debate—with greater implications for the design and cost of public transportation—arose following publication of the Department of Transportation's proposed regulations to comply with the requirements of section 504 of the Rehabilitation Act of 1973.[8]

---

[6] Washington Post, Nov. 10, 1978.

[7] A new report issued by the Urban Mass Transportation Administration (UMTA) provides a better picture of the "Transportation disadvantaged"—those individuals who, while not homebound, have physical problems which result in their having difficulty in using public transportation. UMTA's national study found that there were 7.44 million transportation handicapped individuals in the urban United States, representing 12.1 percent of all urban households.

The elderly comprise a large portion of this group. "The typical transportation handicapped person: Is older (47 percent are 65 and over; 67 percent are 55 and over); has multiple physical problems which create more difficulty in using public transportation than a person without those problems; and has demographic characteristics that are associated with older age, i.e., predominantly female, less educated, lower income, not likely to be employed" (pp. 8-9).

The study also found that transportation handicapped persons took fewer total trips than the general population but more trips for medical and therapy purposes. Buses are the dominant mode of transportation for this group, but nearly half of the transportation disadvantaged either cannot use public transportation, or can use it only with great difficulty, due to multiple barriers which restrict ease of access.—Summary report of the National Survey of Transportation Handicapped People, June 1978; prepared for U.S. Department of Transportation, Urban Mass Transit Administration, Office of Transportation Planning, Management and Demonstrations, Service and Methods Demonstration program.

A. Transbus: Revision of the 1977 Mandate

In May 1977, Transportation Secretary Brock Adams issued an order stating that all new full-sized transit buses purchased with Federal assistance after September 30, 1979, must be of the low-floored, ramped-entrance transbus design. The Secretary based his decision on language in transportation and rehabilitation legislation requiring that elderly and handicapped persons be able to fully utilize mass transit facilities and services.[9]

However, after the protests by the American Public Transit Association and the General Motors Corp. about the potential cost of transbus and an alleged lack of adequate testing, the House Public Works Committee adopted an amendment sponsored by Representative Bud Shuster in May 1978. The Shuster amendment called for the Transportation Secretary to conduct a 3-month field test of the transbus, and report to the Congress a reevaluation of the transbus mandate by January 1, 1979.[10]

The immediate result of the adoption of this amendment was to delay indefinitely bidding by a consortium of cities for transbus vehicles, and the withdrawal of American Motors—which provides about half of the Nation's buses—from the field of manufacture due to "uncertainty" over the final shape of Federal standards.[11] On May 30, 1978, Secretary Adams informed the House Public Works and Transportation Committee:

> I believe that the transbus rule meets the congressional directive that buses be made accessible to the elderly and handicapped in a fair and practical way. I urge you and your colleagues to reconsider the Shuster amendment and the consequences it would have, in view of this overriding concern for the mobility of these disadvantaged citizens.

The Secretary also questioned whether it was practical to meet the January 1 deadline for in service testing, given that problems in tooling for mass production would require test vehicles to be made by hand.[12]

---

[8] The Rehabilitation, Comprehensive Services and Developmental Disabilities Amendments of 1978 (Public Law 95-602, enacted Nov. 6, 1978) made several important changes in the 1973 act. Chief among these was a 4-year extension and increased authorizations for the Architectural and Transportation Barriers Compliance Board (A&TBCB), which is charged with enforcing Federal accessibility statutes by the 1973 act. Under the amendments, the Board is empowered to "establish minimum guidelines and requirements" for standards issued pursuant to the Architectural Barriers Act of 1968, and to "insure that public conveyances, including rolling stock, are readily accessible to, and usable by, physically handicapped persons." As to the cost of compliance with barrier-removal statutes, the Board is directed to report to the Congress, within 1 year, "an assessment of the amounts required to be expended by States and political subdivisions thereof to provide handicapped individuals with full access to all programs and activities receiving Federal assistance."

[9] The 1977 transbus mandate is described in "Developments in Aging: 1977," part 1, pp. 217-18.

[10] National Journal, June 10, 1978, pp. 1476-77.

[11] Wall Street Journal, June 1, 1978, p. 6.

These concerns were apparently resolved on September 14, 1978. DOT revised the transbus mandate to permit manufacturers to meet the accessibility standards with either a ramp or a hydraulic lift, while still requiring that bus floor height be no more than 22 inches. Further, while the September 30, 1979, implementation was retained, DOT issued a statement that it would be "reviewed and reassessed in the near future when the manufacturers' initial delivery commitments for transbus are known."

As a result, the Shuster amendment was deleted on the House floor. The DOT actions may result in the transbus being of a somewhat different design, and may cause first deliveries of the vehicles to be put off until 1983,[13] but they leave intact the Federal decision to require full accessibility in all new transit buses as soon as manufacturers can deliver them.

B. DOT's Proposed Accessibility Regulations

Section 504 of the Rehabilitation Act of 1973 declares:

> No otherwise qualified handicapped individual in the United States . . . shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

The Department of Health, Education, and Welfare was assigned principal responsibility for coordinating governmentwide enforcement of the Rehabilitation Act. On January 13, 1978, HEW issued final rules setting forth guidelines and standards for Federal agencies to follow in implementing section 504.[14] In regard to DOT programs, the HEW standards required that handicapped individuals be afforded program accessibility—utilization of public transportation in the most integrated way possible—within 3 years.

DOT was ordered to draft proposed rules for making its programs accessible within a reasonable and definite period; following the issuance of final rules, transit authorities are given 1 year to prepare detailed transition plans for achieving the required accessibility.

On June 8, 1978, DOT issued its proposed regulations for implementing section 504. The major provisions are as follows:

—All new transit facilities must be barrier free.

—Existing fixed facilities must be made accessible within 3 years, except for mass transit facilities. The limited number of cities with older subway systems[15] would have an extended time period, as yet undetermined but in the range of 12 to 30 years, to make all stations fully accessible.

---

[12] Source cited in footnote 10, p. 1477. On July 12, 1978, a coalition of groups representing the elderly and handicapped held a rally at the Capitol to support the 1977 transbus mandate. In remarks delivered on his behalf, Committee on Aging Chairman Frank Church stated: ". . . I want you to know of my strong support for Brock Adams' transbus mandate, and my opposition to calls for a reevaluation of that decision. America's taxpayers have already spent $27 million studying the need for and feasibility of transbus. How much more study do we need? It has been 8 years since the Congress first declared that the elderly and handicapped have equal transportation rights. Senior citizens need usable transportation now to get to shopping, doctors, friends, and service programs. . . . To ask them to await yet another study is to strain their capacity for patience. To suggest that the elderly and handicapped should be barred from regular transit services and relegated to "separate but equal" transit is to suggest a denial of equal protection that is out of step with the present, and with the law."

[13] Wall Street Journal, Sept. 15, 1978, p. 10; Washington Post, Sept. 15, 1978, p. A10.

[14] 43 Federal Register 2131.

—All new mass transit and intercity rail vehicles must be accessible.

—At least one-half of peak hour bus service must be accessible within 6 years. Because sufficient numbers of transbus vehicles may not be operational by that date, this could require some retrofitting of existing buses with wheelchair lifts.[16]

During September 1978, DOT held hearings in five cities to receive public comments on the proposed rules. Additional comments were accepted until October 20. Final proposed regulations will be forwarded to HEW for review in February 1978, with publication expected in the first part of March.[17]

These proposed regulations have generated considerable controversy due to their projected costs and potential inflationary impact. DOT estimates that the full cost of compliance would total $1.7 billion in 1977 dollars, of which $1.1 billion would be needed to make existing subway systems fully accessible. However, others—such as the American Public Transit Association—estimate these costs at the much higher level of $3 to $5 billion. Such projections have caused concern among officials of the cities and transit authorities that would have to undertake subway renovations and retrofit existing vehicles, despite the fact that Federal transit moneys would cover 80 percent of these costs.

Debate has also extended as to whether these actions are actually required by section 504. Some advocates for the elderly and handicapped argue, however, that section 504 is civil rights legislation, and that costs of compliance cannot be permitted to dilute its clear intent.

Finally, there is no clear consensus as to whether removing physical barriers in existing mass transportation systems is the best means of meeting the transportation needs of the elderly and handicapped. Critics of this approach contend that the provision of more door-to-door paratransit services would provide mobility in a more sensitive and comprehensive manner. Even if physical barriers are removed, they say, the transportation-disadvantaged will still be unable to utilize regular mass transit services due to distances from their home to facilities, bad weather, fear of crime, and routes and schedules which do not correspond to their needs.

Proponents of the barrier-free approach counter that separate transit facilities for the elderly and handicapped are inherently unequal and, due to the high labor costs of paratransit services, can never meet the full mobility needs of this group. Removing barriers to existing services are seen as the best means of providing better service rapidly, while more fully integrating elderly and handicapped individuals with the larger society.

During 1978, the staff of the Regulatory Analysis Review Group, a White House task force charged with calculating the inflationary impact of Federal regulations, recommended that the proposed DOT regulations be modified to require that existing subway stations be made barrier-free only when undergoing major renovations.[18] However, the divergent view taken by HEW; and the lack of common agreement as to the costs and efficiency of removing barriers versus providing special transit services, make this issue particularly difficult. What is certain is that DOT's final regulations for compliance with section 504 will have a substantial long-term impact on the quality, type, and availability of transit services to older Americans who currently experience difficulty in utilizing them.

---

[15] The cities involved are New York, Philadelphia, Chicago, Boston, and Cleveland.

[16] A letter from Secretary Adams to Committee on Aging Chairman Frank Church, transmitting the proposed rules, and a more elaborate summary, including economic costs, are reprinted in part 2 of this report.

[17] Timetable provided by Kenneth Birnbaum, Congressional Liaison Officer, Department of Transportation, Jan. 3, 1979.

III. CONTINUING EFFORTS TO RESOLVE INSURANCE PROBLEMS

The debate concerning accessibility standards has not yet been resolved. However, special transportation services are already being provided to tens of thousands of older Americans with funds secured through DOT and HEW.

A Committee on Aging hearing, held in 1977, revealed that many of these efforts were threatened by skyrocketing insurance premiums, and by restrictions placed on program activities by underwriters.[19]

Several actions have been taken by the executive branch, in response to the facts uncovered by that committee inquiry, which promise to facilitate relief for rural and special transit service operators who are experiencing insurance difficulties.

The Department of Transportation has sponsored an investigation of the extent and causes of the insurance barrier to efficient and reasonably priced special transit. The University of Tennessee Transportation Center, which carried out the project, released its findings in September 1978.[20] Its report made six major recommendations to help resolve current problems:

(1) State laws must better identify and classify social service transit activity.

---

[18] National Journal Oct. 21, 1978, pp. 1672–5.

Further analysis showed that cost was the biggest threat to continuation of programs. The average per vehicle premium reported by AAA's considering termination was $1,000, compared to an average annual cost of $600. Also, the most significant short-term means of reducing premium costs appeared to be joining with units of local government to qualify for fleet rates. AAA's taking this step paid an average of $500 per annum, compared to $750 for those who insured independently.

[19] Details of the hearing are contained in "Developments in Aging: 1977," pp. 222–3. As a followup to the Senate Special Committee on Aging hearing on transit insurance, the Senate computer center was instructed to analyze a questionnaire on this subject distributed by the National Association of Area Agencies on Aging. The center completed its analysis in May 1978, and its most important findings were as follows:

A slim majority of responding AAA's reported no substantial increase in insurance costs, but 45 percent reported annual increases ranging above 25 percent; 17 percent experienced price hikes of 100 to 250 percent. One quarter reported that they could not purchase sufficient coverage. Three-eighths reported experiencing difficulty in retaining or renewing policies. Nearly half of all AAA's reported that insurance costs affected their overall transportation program; 27 percent had to cut back on services, and 10 percent were considering termination of all transportation. One-third reported a cutback in other services in order to pay higher insurance charges. Nearly all had good accident records, with 48 percent reporting no incidents in the preceding year, and an additional 48 percent reporting 1 to 2 accidents. Nearly half felt that their premiums were unjustifiably high. One-sixth are prohibited from employing older drivers under the terms of their insurance policies.

[20] "The Social Service Insurance Dilemma: Problems, Analysis, and Proposed Solutions" by Frank W. Davis, Jr., Ph. D., associate professor, Department of Marketing and Transportation; David A. Burkhalter, legal adviser; William N. Cotterweich, Ph. D., professor of insurance; and Tim Cleary, research associate; Transportation Center, the University of Tennessee, Knoxville, Tenn. 37916; September 1978. Available to the public through the National Technical Information Service, Springfield, Va. 22161.

(2) State laws must be changed to permit social service agencies to purchase insurance that provides certain, unconditional coverage for all users of social service transit.

(3) Congress and executive agencies must take steps to coordinate better benefits which injured users can obtain from a combination of Federal benefit programs, such as medicare, and payments from insurers under tort liability.

(4) The Insurance Services Office, which establishes rating categories for the insurance industry, must develop and collect data for new classifications encompassing social service transit.

(5) Claims procedures should be developed in which social service agencies could help injured parties coordinate the benefits due them under a combination of public programs and private insurance.

(6) The insurance industry and the Government should develop jointly a risk-management program, including driver selection and training procedures, for social service transit.

These suggestions, and others,[21] are now under consideration by a White House task force. That group—chaired by Jack Watson, Assistant to the President for Intergovernmental Affairs—is bringing together representatives of interested congressional units, State and local officials, DOT, HEW, insurance and public utility commissioners, academicians, and the insurance industry to better define the problem and propose coordinated actions to expeditiously resolve it. It is hoped that those recommendations can be the subject of a White House-sponsored meeting early in 1979,[22] and that the actions taken as a result of that forum can provide adequate relief to threatened social service transportation programs. In the meantime, actions are already being taken in some States to provide relief.[23]

ACTION ON NO-FAULT INSURANCE DEFERRED

On May 8, 1978, the Senate Commerce Committee, by a 9–7 vote, favorably reported legislation to the Senate (S. 1381) requiring all

---

[21] Unsuitable vehicles are another factor in operating and insurance cost problems. A recent National Academy of Sciences report found that more than half of the small bus fleets of transit providers were used in fixed route service, and an additional 36 percent provide special transportation for the elderly and handicapped. Yet these vehicles have discouraging operating and maintenance problems and "No fully transitworthy small bus is available on the market . . . the technological gap between what is available and what is needed will become even wider if the accessibility requirements—such as low floors—that have been mandated for large transit buses are applied to their smaller counterparts . . . private industry is hesitant to undertake a costly development program given present market conditions." The academy suggested that the Urban Mass Transit Administration should, with the assistance of consumers, operators, and manufacturers, develop and issue guideline specifications for small buses; and should indirectly support the development of more transitworthy vehicles. Final Report of the Workshop on Small Buses; Transportation Research Board, National Academy of Sciences; September 1978. (Available from Urban Mass Transportation Administration, Office of Policy and Program Development, Washington, D.C. 20590.)

[22] An August 11 Congressional Record statement by Committee on Aging Chairman Frank Church on this White House initiative, and subsequent correspondence between Senator Church and Jack Watson, Secretary of Transportation Brock Adams, and Commissioner on Aging Robert Benedict. Retained in committee files.

[23] In California, the State Department of Aging is surveying all service agencies to determine how insurance hikes are affecting their programs, is improving driver training, and will begin self-insuring all vehicles under State fleet coverage. In addition, the California Coalition for Insurance Reforms for Non-Profit Agencies, a coalition of that State's 37,000 nonprofit organizations, has prepared a risk management and loss prevention manual in an attempt to stem further premium hikes. Further information about this "Risk Management and Auto Liability Insurance Manual," prepared with the advice of the State Department of Aging, is available from the coalition at P.O. Box 418, Pasadena, Calif. 91101.

States to provide drivers with no-fault automobile insurance, and setting minimum Federal standards for that coverage. This action followed 1977 hearings in which Secretary of Transportation Brock Adams, and groups representing the elderly, argued that mandatory no-fault would provide less expensive and more prompt protection for drivers and pedestrians.[24] Proponents of Federal no-fault standards have maintained that the present tort liability system is unfair, provides inadequate benefits, and is slow and inefficient. Opponents have argued that the Federal bill would unduly restrict the right of individuals to seek damages through litigation, and that it would constitute an unwarranted Federal intrusion into State regulation of insurance.

At present, 16 States have full mandatory no-fault insurance: an additional eight States permit compensation from the victim's own insurance company, but do not place limitations on the right to sue. Only Michigan's no-fault plan, however, met the minimum standards of the proposed Federal bill, and that statute was declared unconstitutional by the Michigan Supreme Court in June 1978 because it continued the industry practice of basing premiums on broad classifications such as age, sex, marital status, and residence.[25]

On August 1, 1978, the House Commerce Committee voted, 22–19, not to report this no-fault bill to the full House, effectively ending its chance of passage in the 95th Congress. This issue has been under consideration by the Congress since 1971, and it is expected that another amended no-fault bill will be introduced in 1979.

---

[24] For further background on the Commerce Committee hearings, see "Developments in Aging: 1977," pp. 220–21.

[25] Washington Post, July 17, 1978, p. A15. Wall Street Journal, Sept. 19, 1978, p. 8. In the fall of 1978, the rates and ratings procedures task force of the National Association of Insurance Commissioners recommended that age, sex, and marital status be eliminated as factors in setting auto insurance rates.

CHAPTER XI

AREAS OF CONTINUING OR EMERGING CONCERN

I. MINORITIES

Poverty has declined markedly during the past 10 years for older Americans, from 5.4 million in 1967 to 3.2 million in 1977. (See also chapter II for more information.) Nearly 30 percent of all persons 65 or older were poor in 1967, compared with 14 percent in 1977.

But in terms of aggregate numbers, practically all of the reduction in poverty has been concentrated among aged whites. Nearly 2.2 million elderly whites moved off the poverty rolls from 1967 (4.6 million) to 1977 (2.4 million).

However, the number of aged poor minority members has remained essentially unchanged during the past 10 years (742,000 in 1967 compared with 751,000 in 1977), although their poverty rate has declined sharply—from 51 percent in 1967 to 35 percent in 1977.

The year 1978 brought some moderately good economic news for aged whites, but not for the minority elderly.[1] In some respects, they suffered setbacks. More than 200,000 aged whites escaped from poverty from 1976 to 1977,[2] while the number (from 680,000 in 1976 to 751,000 in 1977) and percentage (from 32.7 percent in 1976 to 34.9 percent in 1977) of low-income aged blacks and other races actually increased. The economic situation for the Spanish-speaking elderly remained essentially unchanged, although the number living in poverty declined from 128,000 in 1976 to 113,000 in 1977. However, this figure (113,000) is still above the number of Spanish-speaking persons 55 years or older living in poverty in 1973 (95,000).

---

[1] Each March, the Bureau of the Census conducts a survey to determine the money income for older and younger Americans for the preceding year. Thus, the 1978 Bureau of the Census survey provides information about the money income of all Americans in 1977.

[2] See following table:

WEIGHTED AVERAGE THRESHOLDS—POVERTY CUTOFFS IN 1977, BY SIZE OF FAMILY AND SEX OF HEAD BY FARM-NONFARM RESIDENCE

Size of family unit	Total	Nonfarm			Farm		
		Total	Male head	Female head	Total	Male head	Female head
1 person (unrelated individual)	$3,067	$3,075	$3,214	$2,969	$2,588	$2,672	$2,498
14 to 64 years	3,147	3,152	3,267	3,023	2,709	2,776	2,569
65 years and over	2,895	2,906	2,936	2,898	2,475	2,495	2,563
2 persons	3,928	3,951	3,961	3,907	3,318	3,325	3,174
Head 14 to 64 years	4,054	4,072	4,095	3,981	3,466	3,474	3,278
Head 65 years and over	3,637	3,666	3,670	3,646	3,128	3,131	3,076

Source: Bureau of the Census

PERSONS BELOW THE POVERTY LEVEL BY FAMILY STATUS, SEX OF HEAD, AND RACE: 1959 TO 1977

[Numbers in thousands. Persons as of March of the following year]

Year, race, and sex of head	Total number below poverty level: All persons	Total number below poverty level: 65 years and over	Total poverty rate: All persons	Total poverty rate: 65 years and over
All persons, all races:				
1977	24, 720	3, 177	11. 6	14. 1
1976	24, 975	3, 313	11. 8	15. 0
1975	25, 877	3, 317	12. 3	15. 3
1974 [1]	23, 370	3, 085	11. 2	14. 6
1974	24, 260	3, 308	11. 6	15. 7
1973	22, 973	3, 354	11. 1	16. 3
1972	24, 460	3, 738	11. 9	18. 6
1971	25, 559	4, 273	12. 5	21. 6
1970	25, 420	4, 709	12. 6	24. 5
1969	24, 147	4, 787	12. 1	25. 3
1968	25, 389	4, 632	12. 8	25. 0
1967	27, 769	5, 388	14. 2	29. 5
1966 [1]	28, 510	5, 114	14. 7	28. 5
1966	30, 424	NA	15. 7	NA
1965	33, 185	NA	17. 3	NA
1964	36, 055	NA	19. 0	NA
1963	36, 436	NA	19. 5	NA
1962	38, 625	NA	21. 0	NA
1961	39, 628	NA	21. 9	NA
1960	39, 851	NA	22. 2	NA
1959	39, 490	5, 481	22. 4	35. 2
White:				
1977	16, 416	2, 426	8. 9	11. 9
1976	16, 713	2, 633	9. 1	13. 2
1975	17, 770	2, 634	9. 7	13. 4
1974 [1]	15, 736	2, 460	8. 6	12. 8
1974	16, 290	2, 642	8. 9	13. 8
1973	15, 142	2, 698	8. 4	14. 4
1972	16, 203	3, 072	9. 0	16. 8
1971	17, 780	3, 605	9. 9	19. 9
1970	17, 484	3, 984	9. 9	22. 5
1969	16, 659	4, 052	9. 5	23. 3
1968	17, 395	3, 939	10. 0	23. 1
1967	18, 983	4, 646	11. 0	27. 7
1966 [1]	19, 290	4, 357	11. 3	26. 4
1966	20, 751	NA	12. 2	NA
1965	22, 496	NA	13. 3	NA
1964	24, 957	NA	14. 9	NA
1963	25, 238	NA	15. 3	NA
1962	26, 672	NA	16. 4	NA
1961	27, 890	NA	17. 4	NA
1960	28, 309	NA	17. 8	NA
1959	28, 484	4, 744	18. 1	33. 1
Black and other races:				
1977	8, 304	751	29. 0	34. 9
1976	8, 262	680	29. 4	32. 7
1975	8, 107	683	29. 3	34. 0
1974 [1]	7, 634	625	28. 3	32. 5
1974	7, 970	666	29. 5	34. 7
1973	7, 831	656	29. 6	35. 5
1972	8, 257	666	31. 9	37. 5
1971	7, 780	668	30. 9	38. 4
1970	7, 936	725	32. 0	46. 2
1969	7, 488	735	31. 0	48. 1
1968	7, 994	693	33. 5	46. 6
1967	8, 786	742	37. 2	51. 0
1966 [1]	9, 220	757	39. 8	53. 4
1966	9, 673	NA	41. 7	NA
1965	10, 689	NA	47. 1	NA
1964	11, 098	NA	49. 6	NA
1963	11, 198	NA	51. 0	NA
1962	11, 953	NA	55. 8	NA
1961	11, 738	NA	56. 1	NA
1960	11, 542	NA	55. 9	NA
1959	11, 006	737	56. 2	60. 8

See footnote at end of table.

PERSONS BELOW THE POVERTY LEVEL BY FAMILY STATUS, SEX OF HEAD, AND RACE: 1959 TO 1977—Continued

[Numbers in thousands. Persons as of March of the following year]

Year, race, and sex of head	Total number below poverty level: All persons	Total number below poverty level: 65 years and over	Total poverty rate: All persons	Total poverty rate: 65 years and over
Black:				
1977	7,726	701	31.3	36.3
1976	7,595	644	31.1	34.8
1975	7,545	652	31.3	36.3
1974 [1]	7,182	591	30.3	34.3
1974	7,467	626	31.4	36.4
1973	7,388	620	31.4	37.1
1972	7,710	640	33.3	39.9
1971	7,396	623	32.5	39.3
1970	7,548	683	33.5	48.0
1969	7,095	689	32.2	50.2
1968	7,616	655	34.7	47.7
1967	8,486	715	39.3	53.3
1966 [1]	8,867	722	41.8	55.1
1959	9,927	711	55.1	62.5

---

[1] Based on revised methodology.

Note. For the year 1959, data for persons 65 years and over and for blacks are based on 1-in-1,000 sample of the 1960 census. For the years 1969 to 1977, data are based on 1970 census population controls.

Source: Bureau of the Census, "Money Income and Poverty Status of Families and Persons in the United States: 1977," (advance report), series P-60, No. 116, issued July 1978, p. 21.

PERSONS OF SPANISH ORIGIN BELOW THE POVERTY LEVEL BY FAMILY STATUS AND SEX OF HEAD: 1972 TO 1977

[Numbers in thousands. Persons as of March of the following year]

Year and sex of head	Total number below poverty level: All persons	Total number below poverty level: 65 years and over	Total poverty rate: All persons	Total poverty rate: 65 years and over
All persons:				
1977	2,700	113	22.4	21.9
1976	2,783	128	24.7	27.7
1975	2,991	137	26.9	32.6
1974 [1]	2,575	117	23.0	28.9
1974	2,601	116	23.2	28.5
1973	2,366	95	21.9	24.9
1972	2,414	NA	22.8	NA
Persons in families with male head: [2]				
1977	1,497	67	15.3	17.6
1976	1,639	76	17.9	22.6
1975	1,802	78	20.1	26.6
1974 [1]	1,563	69	16.9	23.3
1974	1,580	70	17.1	23.6
1973	1,395	54	15.4	19.2
1972	1,592	NA	18.4	NA
Persons in families with female head: [2]				
1977	1,204	46	53.3	34.0
1976	1,144	53	54.3	40.9
1975	1,189	59	55.6	46.8
1974 [1]	1,012	48	51.4	43.7
1974	1,021	47	51.6	42.3
1973	971	42	55.5	41.1
1972	822	NA	51.5	NA

---

[1] Based on revised methodology.

[2] For unrelated individuals, sex of the individual.

Note. Persons of Spanish origin may be of any race.

Source. Bureau of the Census, "Money Income and Poverty Status of Families and Persons in the United States: 1977," (advance report), Series P-60, No. 116, Issued July 1978, p. 24.

On other fronts, some positive developments occurred for elderly minority members in 1978. The Department of Labor selected three minority organizations—National Urban League, National Center on Black Aged, and Asociacion Nacional Pro Personas Mayores—to expand senior community service job opportunities for low-income persons 55 or older in 21 States during program year 1978–1979. Senior aides work in a wide variety of community service facilities and activities, including day-care centers, senior citizen centers, schools, hospitals, nutrition programs, transportation programs, and beautification, conservation, and restoration projects.

Organization	Authorized positions	Funds	States
National Urban League	660	$2,871,000	Connecticut, Illinois, Indiana, Massachusetts, Minnesota, New Jersey, New York, Ohio, Pennsylvania, Virginia, and Wisconsin.
National Center on Black Aged	300	1,305,000	Alabama, Kentucky, Mississippi, North Carolina, and Tennessee.
Asociacion Nacional Pro Personas Mayores	300	1,305,000	California, Kansas, Louisiana, Oklahoma, and Texas.

In addition, the Comprehensive Older Americans Act Amendments of 1978 [3] direct the Administration on Aging to assess future national personnel needs, with special attention devoted to the minority elderly. The 1978 amendments also call upon AoA to train members of minority groups to meet the special needs of aged minority members.

A. NATIONAL CENTER ON BLACK AGED

The National Center on Black Aged engaged in a wide range of activities in 1978, especially in the areas of employment, housing, crime prevention, and training. Major NCBA activities in 1978 include:

—Land was obtained for the construction of a section 202/section 8 housing project for the elderly in the Nation's Capital. NCBA broke ground on the construction of the 175-unit project at the end of the year. In Houston, NCBA and the Eliza Johnson Nursing Home jointly sponsored a 150-unit housing for the elderly project. Present plans call for construction to begin in 1979.

—NCBA maintained a job bank to alert black professionals about possible employment in the field of aging.

—NCBA conducted an antivictimization program on behalf of the elderly in Washington, D.C. The program included three major components: (a) counseling for crime victims, (b) preventive services and education, and (c) escort services to banks, grocery stores, and other services.

—In Springfield, Mass., NCBA operated a transportation program serving about 2,000 people each month. The escort services program operated 6 days a week and provided bus service for older persons to nutrition sites, medical facilities, and shopping centers.

—AoA's quality improvement grant to NCBA to provide technical assistance to minority faculty, educational institutions, and students resulted in five schools receiving funds for gerontological programs. In addition, NCBA helped these schools—University of Arkansas at Pine Bluff, Virginia Union University, Huston-Tillotson College, Mississippi Valley State University, and Prairie View A. & M.—design their gerontological curricula.

---

[3] Public Law 95–478, approved Oct. 18, 1978.

—NCBA developed an annotated bibliography of unpublished material concerning the black aged. NCBA annotated about 300 bibliographical references which coincided with the AoA National Information and Resource Clearing House system.

—NCBA issued a publication concerning major research and training affecting the minority aged.

Dr. Dolores Davis testified on behalf of NCBA at the Senate Committee on Aging's September 8 hearing on "Retirement, Work, and Lifelong Learning." She opposed proposals to raise the eligibility age for full social security benefits. She added, "That is the greatest fear, and because of the differentials of life in the black aged population and other minority populations as well, this is a very, very serious concern." [4]

Dr. Davis provided the following table of life expectancy at selected ages by race and sex:

LIFE EXPECTANCY AT SELECTED AGES, BY SEX AND RACE: 1959-61, 1970 AND 1973

Year and age	Male			Female		
	Black and other races	White	Difference in years	Black and other races	White	Difference in years
1970:						
19590	61.5	67.6	6.1	66.5	74.2	7.7
40	28.7	31.7	3.0	32.2	37.1	4.9
65	12.8	13.0	.2	15.1	15.9	.8
0	61.3	68.0	6.7	69.4	75.6	6.2
40	28.6	31.9	3.3	34.2	38.3	4.1
65	13.3	13.1	.2	16.4	17.1	.7
1973:						
0	61.9	68.4	6.5	70.1	76.1	6.0
40	28.7	32.2	3.5	34.4	38.5	4.1
65	13.1	13.2	.1	16.2	17.3	1.1

Source: Bureau of the Census, 1974. Current Population Reports, series P-23, No. 54, "The Social and Economic Status of the Black Population in the United States," table 81.

Dr. Davis also emphasized that institutional care is oftentimes inaccessible to aged blacks, saying:

> For every 21 white females living in an institution, there is only 1 black female, and, of course, females live longer than the males. We would like to do some research into this because it would have a great impact and meaning for all older persons.[5]

In addition, she pointed out that some Federal programs discourage family members from caring for their spouses. Dr. Davis cited the supplemental security income program as an example. She noted that SSI benefits are reduced for low-income aged, blind, or disabled persons who live in the household of a relative.

---

[4] "Retirement, Work, and Lifelong Learning," hearings before the Senate Special Committee on Aging, Washington, D.C., Sept. 8, 1978.

[5] Testimony at hearing cited in footnote 4.

B. NEW DEVELOPMENTS AFFECTING INDIAN ELDERS

Older Indians are confronted by severe socioeconomic problems. A June 1978 HEW compilation of statistical information on the Indian elderly, based primarily upon 1970 census data, concluded:

> The economic, social, and health situations of persons in the older Indian population were worse than for elderly persons of all races. The proportion of elderly Indians living below the poverty level . . . was nearly double that of the total older population (51 percent versus 27 percent. . . . Although life expectancy among Indians has increased, it is still below that of the general population."[6]

In 1976, with the assistance of a model project grant from the Administration on Aging, the National Indian Council on Aging[7] was established to provide a research and advocacy focus for older Indians, and to speak on their behalf before Congress and the executive agencies.

In August 1978, the Second National Indian Conference on Aging was convened by the council in Billings, Mont. Health care was the primary focus of this gathering. However, the 3,000 participants also discussed the full range of problems and programs affecting Indian elders.

Committee on Aging Chairman Frank Church, in remarks prepared for the conference, stated:

> In those 2 years you have made commendable progress. The National Indian Council on Aging has become an effective voice and agent for action. Its testimony . . . and diligent work have brought about one of the most important goals which you set in Phoenix—under the newly revised Older Americans Act . . . tribes may now choose to receive their funding for aging services directly from the Commissioner on Aging in Washington.[8]

The conference also received messages from Committee on Aging member John Melcher and ranking Republican Pete V. Domenici, who described his efforts to strengthen tribal authority for health planning, and to focus greater resources on the continuing problem of alcoholism. Montana Gov. Thomas Judge noted that, due to the high incidence of early death, disease, and poverty among Indians, his State had successfully sought to have Indians considered "old" at age 45 for Older Americans Act purposes.[9]

Ranking Minority Member Senator Pete V. Domenici introduced an amendment to the Older Americans Act to permit direct funding to Indian tribes. The amendment establishes a separate title to authorize the Commissioner to make funding directly available to tribal organizations to pay all the cost for delivering social and nutritional services to older Indians.

---

[6] "Social, Economic, and Health Characteristics of Older American Indians," June 1978, Administration on Aging, DHEW publication No. (OHDS) 78-20289; p. 16.

[7] For further information about the National Indian Council on Aging, inquiries should be directed to P.O. Box 2088, Albuquerque, N. Mex. 87103.

[8] Title VI of the revised Older Americans Act is described in greater detail in chapter VI.

[9] Billings Gazette, Aug. 18, 1978, p. B1.

Participants at the Billings conference singled out two areas for special concern. First, complaints were voiced that present Federal policies put the approximately 25,000 older Indians residing in urban areas in competition with those living on reservations for funding assistance, and fail to establish clear responsibility for addressing the needs of urban Indians. Second, it was reported that few advances had been made in improving the housing conditions of older Indians.

Earlier in 1978, a GAO report [10] confirmed this lack of progress on shelter, finding that:

> The number of Indian families living in substandard housing has increased from 63,000 in June 1970 to 86,500 in June 1978, while the number of new units started annually has dropped from 5,000 to 3,500.

The GAO found that existing Federal programs could meet the increasing housing needs of all Indians, if properly carried out and funded.

The GAO also noted that HUD's "slow and cumbersome" administrative system, combined with a lack of adequate staff and resources on the part of Indian housing authorities, contributed to the problem. It concluded:

> Existing Federal programs have not been successful in meeting the Indian housing needs because they are underfunded, have not received enough emphasis, require too many complex and time-consuming procedures, lack flexibility, require more trained people, and are uncoordinated.
>
> The present goal of eliminating substandard housing on Indian reservations in the 1970's cannot be achieved under present programs and is no longer feasible.

GAO recommended that the Congress consolidate all Indian housing programs, and develop a new range of flexible housing assistance mechanisms, in a single Federal agency. Congress has not yet acted on these recommendations. HUD, however, has proposed sweeping revisions of its Indian program regulations in response to criticism from the GAO and other sources.[11]

The National Indian Council on Aging is now directing priority attention to the two major objectives established at billings—the development of home health services and reservation-based nursing homes—and to assure that the Congress provides adequate appropriations for title VI (grants for Indian tribes) of the revised Older American Act.

C. ACTIVITIES OF THE ASOCIACION NACIONAL PRO PERSONAS MAYORES

The Asociacion Nacional Pro Personas Mayores was established in 1975, with the assistance of an AoA model project grant, to promote greater involvement of the Hispanic elderly in State and Federal aging programs, and to assist researchers and lawmakers to better understand the needs of the elderly members of the Hispanic ethnic groups.

---

[10] "Substandard Indian Housing Increases Despite Federal Efforts—A Change Is Needed," GAO report CED-78-63, Mar. 31, 1978.

[11] "Housing Affairs Letter," Jan. 19, 1979, p. 6.

The asociacion furthers these goals through its participation in Congressional hearings, gerontological conferences, and ongoing research. It has also established a national office and a number of regional centers, which were involved in these activities during the year:

—Southeastern center. The Miami office participated in the Dade County Transportation Board's policy deliberations on matters affecting the elderly and handicapped. The center established a working relationship with the Miami Jewish Home for the Aged, and presented testimony at a wide range of public hearings.

—Eastern center. The development of innovative outreach and technical assistance programs for Hispanic elderly in the Northeastern part of the Nation has been the primary goal of the New York City office. Training programs for senior centers and for Hispanics wishing to enter the field of aging have been established, as well as working relationships with the gerontology departments of Fordham University, Manhattan University, and Hunter College. To promote better outreach, a weekly broadcast prepared by the New York office is broadcast over a local Spanish language radio station.

—Southwestern center. The Albuquerque office has developed a special focus on the rural elderly, and during 1978 the Council on Rural Elderly of New Mexico was established to focus the attention of Federal aging programs to the special needs of the Hispanic elderly. However, due to a decrease in funding, the asociacion was forced to temporarily close this center until an alternate, private funding mechanism can be created.

—Western center. The Los Angeles office serves Southern California, which has one of the Nation's largest Hispanic community. The center has particularly stressed the development of nutrition and transportation services, and has promoted the increased participation of Hispanics in aging programs.

—National office. The Washington office entered its fourth year of operation, and has been named as a national sponsor by the Department of Labor for the senior community service employment program under the Older Americans Act. The national center's immediate goal is to locate sources of private funding to supplant reduced grants from the Administration on Aging.

NEW DATA ON HISPANIC HOUSING

Federal activities outside the AoA also affect elderly Hispanics. In 1978, HUD's Department of Policy Development and Research released a new compilation of data on the housing conditions of Hispanics. Generally, HUD found that only 71 percent of Hispanics could afford adequate housing without spending more than one quarter of their income, Cubans are better housed than most Hispanic minorities. Mexican-Americans suffer worse housing conditions than the average American family, and only 48 percent of Puerto Ricans, compared to 80 percent of all U.S. households, can find adequate housing for one quarter of their income.

Among the low-income elderly Hispanics, men living alone reside in poor quality housing, while Hispanic women were the least likely to live in such units. The table below shows the probability of a very poor aged Hispanic residing in inadequate housing, in comparison to other racial and ethnic groups:

THE CHANCE OF BEING INADEQUATELY HOUSED ALSO DEPENDS ON AGE, SEX, AND FAMILY SIZE

Other demographic characteristics of the household			Race/ethnicity				
Age of head	Household size	Sex of head	Hispanic	White (excluding Hispanic)	Black (excluding Hispanic)	Ratio of Hispanic to white probability [1]	Ratio of Hispanic to black probability [1]
65 and up	1 person	Female	0.18	0.13	0.27	1.4	0.7
		Male	.56	.27	.43	2.1	1.3
	2-5 persons	Female	.24	.16	.33	1.5	.7
		Male	.21	.13	.27	1.6	.8

[1] Probabilities refer to a household with an adjusted income of less than $2,500 living in an SMSA under 250,000 in population located in the North Central census region.

Source: "How Well Are We Housed?" Hispanics, HUD PDR-333, September 1978, p. 18.

In August 1978, HUD awarded a 2-year, $785,000 grant to the National Hispanic Coalition for Better Housing (NHCBH) in order to better assure the full participation of Hispanics in the development of housing and community development programs. NHCBH will assess the housing needs of the Hispanic community, and identify local Hispanic groups involved in housing activities. Staff members from those groups will then receive training and technical assistance. These activities should help to insure that Federal housing programs better serve Hispanics, including the elderly.[12]

D. FINAL REPORT ON THE PACIFIC/ASIAN ELDERLY

The Pacific/Asian elderly research project (PAERP) was established in 1976 with the assistance of an AoA grant. PAERP is dedicated to the development of health and social services which can be effectively delivered to and utilized by the elderly of oriental and Pacific ethnic background.

PAERP's final report[13] was issued in May 1978. Its major conclusions were:

—There is a major continuing need for research on the current status of service delivery strategies directed to this group of elderly.

—Community based research, emphasizing cooperative efforts, is the most desirable, practical, and beneficial means of fulfilling further data needs.

—Greater efforts must be undertaken to disseminate information on the Pacific/Asian elderly to researchers, service providers, and community organizations. This can best be accomplished through the establishment of a national clearinghouse.

---

[12] The University of Southern California's Andrus Gerontology Center has developed a unique research program dubbed project MASP (minority aging and social policy) to develop and disseminate data about the minority aged. A 1978 publication, "Housing: The Diverse Aged," focused on the shelter issues, policies, and concerns of Los Angeles' elderly. Persons wishing further information about project MASP should contact the Sociology of Age Laboratory, Ethel Percy Andrus Gerontology Center, USC, Los Angeles, Calif. 90007.

[13] "Final Report of the Pacific/Asian Elderly Research Project," May 1978, prepared under AoA Grant No. 90-A-980/02. PAERP, 2400 South Western Avenue, Suite 206, Los Angeles, Calif. 90018. The special needs and problems of Japanese and Chinese elders were considered in a December 4 committee hearing on "Older Americans in the Nation's Neighborhoods" in Oakland, Calif. See chapter VIII for details.

—Pacific/Asian communities need better technical assistance in order to develop and implement service delivery systems.

—Further assessment of the desirability and feasibility of establishing a national Pacific/Asian elderly organization—including a cost-benefit analysis and a clarification of functions—is required prior to making a final decision on this matter.

—A clarification is needed of the present interrelationships between service delivery methods, organizational developments, and research.

The report also found that the Pacific/Asian elderly have unique service needs growing out of their cultural heritages which require a sensitivity on the part of service providers. Bicultural and bilingual staffs and services were deemed essential to successful efforts, particularly if they are to accommodate the general inclination of this ethnic grouping to seek assistance from friends and family, rather than a public agency.

Those involved in PAeRP will continue their gerontological research and service delivery efforts, and their report will be considered by congressional and AoA officials as steps are taken to make Older Americans Act services better serve this group.

II. DEVELOPMENTS IN AGE DISCRIMINATION ACT

The Age Discrimination Act (ADA) of 1975 (Public Law 94–135) provides that "no person in the United States shall, on the basis of any age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance." The law exempts employment programs which fall under the jurisdiction of the Age Discrimination in Employment Act of 1967 (Public Law 90-202).[14] The ADA statute defines three other categories which could be exceptions:

(1) If such action reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of such program or activity.

(2) If the differentiation made by such action is based upon reasonable factors other than age.

(3) The provision of the act shall not apply to any program or activity established under the authority of any law which (a) provides any benefits or assistance to persons based upon the age of such persons; or (b) establishes criteria for participation in age-related terms or describes intended beneficiaries or target groups in such terms.

It was recognized when developing the ADA it would be essential to define the distinctions between practices which were discriminatory on the basis of age and those which were not before full implementation of the act could take place. For this reason, the statute required a study of age discrimination in federally assisted programs and activities, to be conducted by the U.S. Commission on Civil Rights and presented to the Congress before the promulgation of regulations. This study was presented to the Congress in December 1977. It concluded:

---

[14] Although the Age Discrimination Act does not apply to employment practices, its authority does cover the Comprehensive Employment and Training Act (CETA).

> Barriers have been erected by both public and private administrators between persons falling within particular age groups—especially children and older persons—and services which are financed in whole or in part by the Federal Government, and erection of these barriers has had and is having a serious adverse impact on the lives of children and older persons who need these services—it is a depersonalized approach which is in direct conflict with the concept of the dignity and worth of the individual.[15]

A. THE 1978 AMENDMENTS

> I feel that one of the most effective things that can be done is for the Congress to exercise the kind of leadership that is reflected in the Age Discrimination Act, and to do it in such a way that the line is drawn sharply by the Congress because of the belief of Congress that service and benefit programs financed by the Federal Government should be handled in a manner that is consistent with the concept of the dignity and worth of each individual.[19]

Arthur S. Flemming, Chairman of the U.S. Commission on Civil Rights, appeared before the Congress in January 1978 to present the Commission's recommendations for amending the Age Discrimination Act before its implementation. The Commission's legislative recommendations were based on its 2-year study and report on documented age discrimination in service and benefit programs. Congressman John Brademas, chairman of the House Subcommittee on Select Education, heard testimony from the Commission during oversight hearings on the Age Discrimination Act of 1975. Brademas described the law as being "founded on the belief that it is a fundamental injustice to deny to any individual access to the fruits of our society based on arbitrary age criteria." He used many of the recommendations of the Commission as the basis for his amendments to the ADA as incorporated in H.R. 12255, to amend the Older Americans Act, Domestic Volunteer Service Act, and Age Discrimination Act. Several of these amendments to the ADA and others were included in the final legislation Public Law 95–478. The 1978 amendments to the Age Discrimination Act include:

(1) Striking of the word "unreasonable" from section 302 of the original 1975 statute in order to remove any suggestion that all other forms of adverse discrimination are by definition reasonable and lawful.

---

[15] "The Age Discrimination Study," a Report of the U.S. Commission on Civil Rights, December 1977. In addition, for a detailed description of the age discrimination identifications and recommendations in the Commission on Civil Rights study, see chapter IX of "Developments in Aging: 1977," U.S. Senate Special Committee on Aging.

[19] Testimony by Hon. Arthur S. Flemming, Commissioner, U.S. Commission on Civil Rights, before the Subcommittee on Select Education, U.S. House of Representatives, Jan. 20, 1978.

(2) Granting a private right of action to those individuals who, after a 180-day negotiation period, have not reached an agreement with the agency being charged.

(3) Allowing Federal agencies who enforce the ADA to "bypass" any State or local recipients of Federal assistance who are found guilty of age discrimination and disburse such funds to other agencies capable of providing the appropriate services and/or benefits.

(4) Requiring the Secretary of HEW to approve all regulations governing the ADA which are required of all agencies and departments who provide Federal financial assistance.

(5) Delaying the ADA's original implementation date of January 1, 1979, to July 1, 1979, in order to allow the necessary time for issuance of proposed and final regulations by each department and agency.

Senator Frank Church, chairman of the Senate Committee on Aging, applauded the amendments as strengthening the ADA by providing "far-reaching effects on the elderly as well as other age groups." [17]

B. The Proposed Regulations

On December 1, 1978, the Department of Health, Education, and Welfare proposed the statutory requirement for general regulations to carry out the Age Discrimination Act of 1975.[18] These proposed regulations will guide the Federal agencies and departments in developing their required specific regulations, and will attempt to interpret the enforcement of ADA and the amendments of 1978.

Secretary of Health, Education, and Welfare Joseph Califano sent copies of the regulations to all Members of Congress, saying: "Since the impact of this act and these regulations will be considerable, I am making every effort to expose the regulations to broad and searching public scrutiny." [19]

These efforts for "public scrutiny" are extensive. The public's comments were invited on "which age distinctions seem rational and necessary, and which are based on nothing more than stereotypes and misconceptions about the abilities and needs of persons of different ages."

In addition, the public was asked to "identify uses of age which might not be prohibited by these regulations, but should be prohibited . . . and those which may be prohibited by these regulations, but should not be prohibited."

Public comment is further encouraged by the format of the proposed regulations. Instead of having a specific departmental position on several of the more important provisions of the ADA, the Department chose to adopt "alternatives" for comment. Each alternative is discussed and an indication is given to which alternative "the Department is leaning toward." Therefore, if insufficient comment or rationale is received justifying one of the alternatives, then the final regulations will most probably reflect the position to which the Department indicates it is leaning.

---

[17] Statement of Senator Frank Church upon Senate adoption of the conference report on the Comprehensive Older Americans Act Amendments of 1978, Congressional Record, Oct. 7, 1978, p. S17683.

[18] Federal Register, vol. 43, No. 232, Dec. 1, 1978.

[19] Letter from Secretary Joseph Califano, Department of Health, Education, and Welfare, to Members of the U.S. Senate, December 1978.

THE PROPOSED CONTENTS

The Age Discrimination Act of 1975, as amended, is substantially different from other civil right statutes. This differenec is centered around the fact that the ADA prohibits age discrimination but allows certain exceptions to be made on certain age distinctions and reasonable factors other than age.

These exceptions are the basis for the Department's concern about interpretation of the statute and therefore, the issuance of alternative positions in the proposed regulations. The major areas of importance for which the Department lists options are those which will govern the law's scope of authority.

First, the Department seeks comment on language stating that the act does not have authority over programs or activities "established under the authority of any law." The proposed regulations give four options for what is meant by "any law":

(1) A Federal statute, State statute, or local statute or ordinance, or Federal, State, or local regulation; (2) a Federal statute, State statute, or local statute or ordinance; (3) a Federal statute or State statute; or (4) a Federal statute, which;

> (a) provides any benefits or assistance to persons based on age;
>
> (b) establishes criteria for participation in age-related terms; or
>
> (c) describes intended beneficiaries or target groups in age-related terms.

The difference in impact between options 1 and 4 is considerable. Option 1 would make the scope of enforcement of the ADA very narrow; option 4 would allow only the Congress to legislate where age distinctions are legal. The Department indicates it is "leaning toward" option 3 (section 90.3).

An area closely related to the definition of "any law" is the definition of the act's term "statutory objective." The Department proposed two alternatives for this definition: One, "statutory objective" includes any purpose expressly stated in a statute. Or, the other option would be to define "statutory objective" as including any purpose either expressly stated in a statute or inferred from its provisions or legislative history (sec. 90.13).

A third area needing clarification is an exception based on "reasonable factors other than age." The Department states that it could be interpreted as meaning a rational, direct, substantial, or necessary relationship to the normal operation of a program or activity, or to the achievement of a statutory objective. The Department states that it believes that the Congress intended this exception to be a "less rigorous" one and, therefore, would prefer regulatory language stating the exception as one which "bears a rational relationship" to normal program operations or statutory objectives.

Adoption of the other terms (direct, substantial or necessary) is thought to result in more restrictive interpretation of this exception, whereas use of the term "rational" could mean utilizing a test similar to the "rational relationship" test applied by the courts to challenges under the equal protection clause of the 14th amendment (sec. 90.15).

Other regulations being proposed include:

—A listing of the actions which could be reasonably taken into account when determining "a factor necessary to the normal operation or the achievement of any statutory objective, including: (a) Age is used as a measure or approximation of one or more other characteristics (that is, maturity); (b) the other characteristic(s) must be measured or approximated in order for the normal operation of the program or activity to continue, or to achieve any statutory objective of the program or activity; (c) the other characteristic(s) can be reasonably measured or approximated by the use of age; and (d) the other characteristic(s) are difficult, costly, or otherwise impractical to measure directly" (sec. 90.14).

—A requirement placing the burden of proof on the recipient of Federal assistance to determine which of its age distinctions or factors other than age is entitled to any of the exceptions listed above (sec. 90.16).

—A requirement that each agency receiving Federal assistance must conduct a review of any age distinctions being practiced in policy or regulation and publish the results of this review and a listing of such age distinctions in the Federal Register (sec. 90.32).

—A requirement that each agency receiving Federal financial assistance must submit annually to the Secretary of DHEW all information and data pertaining to the agency's enforcement of the ADA.

—A requirement that each agency extending Federal financial assistance must provide written notice, technical assistance and educational materials to all of their recipients (sec. 90.43(b)).

—A requirement that each agency extending Federal financial assistance must require each of its recipients to conduct a written self-evaluation of its compliance under the ADA within 18 months of the effective date of the agency regulations (sec. 90.43(c)).

—A requirement that each agency extending Federal financial assistance shall refer all complaints to a mediator and require the participation of the recipient and the complainant in the mediation process (the Department and Office of Management and Budget are considering requiring that all such mediation processes be conducted by the Federal Mediation and Conciliation Service who would train mediators from its staff or the community to handle the ADA complaints (sec. 94.43(d)).

—A requirement that each agency extending Federal financial assistance must develop a procedure for disbursing funds to another recipient if it is forced to bypass a recipient who is found to be out of compliance with the ADA (sec. 90.47).

—A requirement that each recipient found to have discriminated on the basis of age must take any action necessary to remedy the situation and overcome the effects of the discrimination (sec. 90.49).

C. Implementation

Under the 1978 amendments to the Age Discrimination Act, the effective date of the regulations was delayed from January 1, 1979 to

July 1, 1979. This time lapse is necessary for the final promulgation of the general regulations issued on December 1, 1978, by the Department of Health, Education, and Welfare and the issuance of proposed and final regulations by each agency and department who provide Federal financial assistance. Therefore, the first half of 1979 will be a very important period toward the enactment of the ADA.

This time period for the completion of the regulatory process required by the ADA will be structured in accordance with the promulgation of the general regulations which were proposed on December 1. These regulations will be open for comment until February 28, 1979. Then, the issuance of the final general regulations will occur within a month of this time. These final regulations will govern the agencies and departments drafting of their specific regulations to enforce the ADA. These specific regulations will be issued in proposed form for public comment. After the comment period has ended, the agencies "and departments" final specific regulations will be issued, but not before July 1, 1979.

III. ACTIONS ON ENERGY COSTS, WEATHERIZATION

Older Americans, particularly those living on fixed incomes, have been severely affected by increasing energy costs which are currently rising at a rate faster than the Consumer Price Index.[20] The National Energy Act, an altered version of the administration proposal, provides new incentives and assistance for residential insulation, encourages the States to move toward more equitable utility rate systems, and improves Federal weatherization programs for low-income elderly. However, it is likely that the gradual decontrol of natural gas prices will result in increased costs to consumers of this fuel.

Concern continues about irregularities in our present Federal weatherization programs designed to assist the poor. And better ways of insuring that elderly consumers do not experience service terminations due to nonpayment of utility bills during harsh winters are still being sought.

A. The National Energy Act

On October 15, 1978, the Senate and House adopted the conference report on the National Energy Act.[21] This comprehensive legislation contains a number of provisions of importance to the elderly:

Low-income weatherization assistance.—The act retains language introduced by Committee on Aging Chairman Frank Church which brings the new Department of Energy (DOE) weatherization effort into uniformity with similar programs now being administered by the Community Services Administration (CSA).[22] DOE assistance will now be available to all persons with incomes up to 125 percent of poverty level, with special emphasis placed on helping elderly individuals. The limit on costs for insulation materials was doubled to $800 per dwelling. Consultation is required between CSA and DOE, and older workers employed under title V of the revised Older Americans Act are permitted to participate in DOE weatherization efforts.

---

[20] Hearings held by the Committee on Aging on "The Impact of Rising Energy Costs on Older Americans," as well as a description of the original National Energy Act, are contained in chapter III of "Developments in Aging: 1977."

[21] Public Laws 95-617-21, enacted Nov. 9, 1978.

[22] The CSA also operates a program of emergency energy assistance for low-income individuals who cannot fully pay their fuel bills. Its history and status are discussed in chapter VII.

Residential tax credits.—Homeowners are provided a nonrefundable tax credit of 15 percent of the first $2,000 (maximum: $300) spent on insulation and other energy conservation improvements—such as flue and furnace modifications, and storm doors and windows—between April 20, 1977, and January 1, 1986. These credits can be carried over for 2 years, through January 1, 1988, if they exceed the amount of tax owed by the homeowner.[23]

Stronger incentives are provided for the installation of solar, wind, or geothermal energy equipment in principal residences. A nonrefundable credit of 30 percent of the first $2,000, and 20 percent of the next $8,000 (maximum: $2,200) of such expenditures, made between April 20, 1977, and January 1, 1986, is authorized.

Utility rate reforms.—State utility commissions and other regulatory bodies are required to consider new rate structures to encourage conservation at hearings during the next 2 years. Changes to be considered, on a utility-by-utility basis, include lifeline rates for elderly or low-income individuals, and discounts for using electricity in off-peak periods. The Department of Energy is authorized to participate fully in the ratemaking process, including appeals, on behalf of energy conservation steps.

Conservation assistance.—Electric and gas utilities are required to offer their customers a home energy evaluation service in order to assist with informed decisionmaking about weatherization expenditures. Utilities are prohibited from actually selling or installing conservation measures, but they are required to help arrange for weatherization and to arrange financing if customers request it. Customers, at their option, can pay for improvements as a portion of their monthly fuel bill; utility service cannot be terminated if a customer falls into arrears in repaying conservation financing. Utilities are also permitted to make direct weatherization loans up to $300.

Such assistance will not be fully implemented until final regulations are published by DOE, sometime late in 1979. The act, once fully implemented, should provide considerable assistance to older homeowners in their conservation and weatherization efforts.[24]

Natural gas deregulation.—Prices of newly discovered natural gas will be permitted to rise about 10 percent annually until January 1, 1985, when all price controls will be ended. Industrial and other commercial users, rather than residential customers, will be required to bear the brunt of these price increases until decontrol occurs. Some

---

[23] Improperly treated cellulose—the most popular insulation material—can present fire and corrosion hazards. The Consumer Product Safety Commission now sets safety standards for insulation materials, and consumers are advised not to purchase weatherization products lacking Government specifications.

[24] Some States have enacted more extensive conservation programs. Oregon, for example, provides low-interest loans for conservation measures; requires utilities to provide a range of weatherization services; gives low-income elderly individuals property tax or rent refunds to offset utility costs, as well as weatherization grants; and has established a consumer protection network to oversee the conservation industry. Homeowners are also permitted a State income tax credit for conservation. As of May 1978, more than 1,000 elderly taxpayers had received more than a quarter-million dollars in tax credits; and almost 60,000 elderly with incomes under $5,000 had received about $3 million from the utility rate relief program. New York Times, May 7, 1978, p. 61.

Federal price controls will be extended for the first time to the intrastate gas market.

Starting 6 months after price controls end, either the President or the Congress can, within a 2-year period, reimpose controls for up to 8 months if prices are deemed to be rising too rapidly. By the end of 1988, all controls must be terminated in the absence of new legislation.

B. THE GAO WEATHERIZATION REPORT

While the Church amendment to the National Energy Act brought the DOE and CSA weatherization programs under uniform standards, difficulties in administering Federal efforts to help the poor insulate their dwellings remain unresolved.

An August 1978 report by the General Accounting Office [25] found a number of problems, including:

—A failure on the part of the Community Services Administration to provide sufficient guidance, require program controls, or adequately monitor program operations. These have contributed to problems in the administration of weatherization efforts by local grantees.

—A lack of availability of sufficient trained manpower due to ineffective implementation of the working agreement between CSA and the Department of Labor. This results in improper use of materials due to poor workmanship and an inability to complete substantial portions of weatherization work prior to winter's onset.

—A systematic exclusion by CSA of rental housing, which constitutes the shelter of a majority of the Nation's poor. This has resulted from a lack of guidance on operating the program in a way which is equitable to the Government, tenants, and landlords. However, weatherization of multifamily housing could be accomplished at a lower cost per household than single-family dwellings.

The GAO did note that, in August 1977, DOE, CSA, and the Department of Labor signed an agreement of understanding to encourage better information exchange; joint research, demonstration, and evaluation efforts; and coordinated planning, funding, and employment strategies. But additional issues—in particular, uniform technical standards for weatherization materials, and criteria for rental units—remained to be resolved.

The GAO advanced several recommendations to improve Federal weatherization efforts for the poor, including:

—The establishment of procedures, including periodic reporting, to resolve interagency disagreements, with additional oversight carried out by the Office of Management and Budget (OMB).

—The provision of affirmative guidance from CSA to grantees for the weatherization of rental property, including the requirement that grantees submit goals for implementation.

—A congressional clarification of the roles of CSA and DOE in future Federal weatherization efforts. GAO suggested that the Congress consider placing all responsibility for this program in DOE, with CSA retaining responsibility for the emergency energy assistance program, and providing the Secretary of Labor with the authority to set aside Comprehensive Employment and Training Act (CETA) funds for weatherization manpower.

---

[25] "Complications in Implementing Home Weatherization Programs for the Poor." GAO report HRD-78-149, Aug. 2, 1978.

In response to the GAO report, both CSA and OMB agreed that the primary responsibility for low-income residential weatherization should be placed in the Department of Energy. CSA also agreed that better coordination of CETA plans with weatherization efforts was needed, but expressed a preference for direct labor funding for its efforts. Labor, on the other hand, proposed to develop procedures to encourage CETA prime sponsors to cooperate in resolving weatherization difficulties. DOE generally concurred with all the GAO recommendations. All three agencies questioned the appropriateness of OMB oversight of the interagency agreement.

As 1979 began, the Department of Energy issued new amendments to its weatherization regulations[26] which permit greater flexibility in program operation at the State and local levels. For fiscal 1979, the Congress provided no direct funding for community action agencies from CSA for weatherization, but did appropriate $200 million for DOE's grant program, which is administered by the States. This action ended the split funding of Federal weatherization efforts. However, while the source of funding has been centralized, the weatherization program continues to be implemented by the network of 900 local community action agencies. Further, DOE has already implemented the changes in their weatherization program mandated by the Church amendment. DOE has also started demonstration projects in an effort to resolve the difficulties which have prevented the extension of weatherization assistance to low-income households residing in rental property.[27]

The changes initiated by GAO's scrutiny and congressional reforms may have far-reaching results. GAO noted that, according to CSA estimates, this effort could result in the conservation of nearly 3 million barrels of oil annually, as well as a reduction of the fuel costs of poor households by $60 million. However, a resolution of the difficulties of reaching rental housing, and better assurances of trained labor, are required for the program to reach its full potential.

C. CONCERN ABOUT UTILITY TERMINATIONS

The Public Utilities Regulatory Policies Act, one of the five parts of the National Energy Act,[28] sets Federal standards for procedures to be followed in the termination of electric service and natural gas to consumers. It requires that they be given reasonable prior notice, including their rights and remedies, and a reasonable opportunity to dispute termination. Further, during any period when termination would be especially dangerous to health, no termination may take place if the consumer establishes that he is unable to pay, or can do so only in installments. Elderly and handicapped consumers are singled out for priority attention.

Under this act, State regulatory authorities must, within 2 years after enactment, adopt these standards, or state in writing their reasons for not doing so. In addition, within 1 year after enactment, regulatory authorities must begin to submit an annual report to the Secretary of Energy regarding compliance with these and other standards. Based on those reports, the Secretary must submit to the President and Congress an annual summary of State actions, and recommendations for further necessary Federal steps. The Secretary also has the power to intervene in ratemaking and judicial procedures to advocate adoption of these standards.

---

[26] Federal Register, Jan. 2, 1979, p. 51.

[27] Information supplied by Mary M. Bell, director, Office of Weatherization Assistance, DOE, on Jan. 17, 1979.

[28] Public Law 95-617. Standards for electric utilities are contained in title I, subtitle B, and for natural gas utilities in title III. The Department of Energy's powers for intervention and enforcement are set out in title I, subtitle C, and in title III, section 305.

In the fall of 1978, a coalition of labor and civic organizations was formed to seek immediate compliance with these termination standards, citing at least 200 deaths resulting from fuel cutoffs during recent winters. William Hutton, director of the National Council of Senior Citizens, stated that the elderly were being confronted with "life-and-death economic choices. . . . In fact, they've had to make the cruel choice between heating or eating in many cases."[29] The coalition announced that it would focus its immediate efforts on State regulators in 23 selected States, seeking bans on winter terminations such as those already in effect in Wisconsin, Maryland, and Rhode Island.

IV. NATIONAL INSTITUTE ON AGING

The National Institute on Aging made some gains in 1978, but was limited to a $7 million increase in its budget. Operating on a budget of approximately $37.7 million, the NIA supported 325 grants and contracts in 1978, only 49 above the previous year. Mandated by law to conduct biomedical, social, and behavioral research,[30] the Institute distributed its awards as follows:

—209 awards (64.3 percent) for biomedical/biological efforts.
—79 awards (24.3 percent) for behavioral/societal efforts.
—23 awards (7.1 percent) for clinical efforts.
—14 awards (4.3) for multicategorical efforts.

Of the NIA's $37.7 million budget, $26.3 million was used to support these awards for research (83.4 percent), training (9.1 percent), and contracts (7.5 percent).

The Institute attempts, according to Director Robert Butler:

> . . . to find ways to reverse, delay, or in some other way ameliorate the deleterious effects of human aging, and in this way enhance the overall quality of life. These efforts would also contribute to increased life expectancy, as would the research being conducted by the other National Institutes of Health.[31]

In addition to its grants and contracts, the NIA influences research, training, and social services through conferences and workshops with other institutes and agencies. For example, during 1978 the NIA conducted joint efforts with:

—The National Institute of Mental Health and the National Institute of Neurological and Communicative Disorders and Stroke on senile dementia/Alzheimer's disease and related disorders.

---

[29] Washington Post, Nov. 15, 1978, p. A15.

[30] Public Law 92-296, Research on Aging Act.

[31] Remarks by Robert N. Butler, M.D., Director, National Institute on Aging, National Institutes of Health, at conference on "Frontiers in Aging: Life Extension," University of Minnesota, Apr. 27, 1978.

—The Fogarty International Center on treatable brain diseases.

—The National Institute of Mental Health on "The Older Woman: Continuity and Discontinuity."

—The National Institute of General Medical Sciences on pharmacology/aging.

—The Fogarty International Center on persons thought to be centenarians in Vilcabama, Ecuador.

The Institute also sponsored a workshop with experts and practitioners on nutrition and the aging; contracted with the Boston collaborative drug surveillance program to study the age-related effects of drugs; initiated a special "think tank" within the National Institutes of Health to examine the social, behavioral, and medical ramifications of the revised retirement policies; and brought together a group of physicians, researchers, scientists, ethicists, and lawyers to discuss methods of protecting elderly research subjects.

The Institute's own structure grew during the year with the establishment of the position for an associate director of epidemiology, demography, and biometry. The NIA's study of the effects of race, gender, and ethnic factors on disease in the elderly will be enhanced with the addition of this position. More studies on the relationship of hypertension and nutrition in the elderly are also expected.

The Institute's intramural program at the Baltimore Gerontology Research Center continued to expand research efforts, with the addition of women to the longitudinal study. Many of the women subjects are related to the men who have been studied since 1958; the GRC also will be looking at the possibility of a family longitudinal study.

A. The Research Plan

Public Law 92–296, which created the National Institute on Aging, also mandated that the Institute and its advisory council develop "a plan for a research program on aging designed to coordinate and promote research into the biological, medical, psychological, social, educational, and economic aspects of aging." This plan, "Our Future Selves: A Research Plan Toward Understanding Aging," was presented to the Congress in December 1977.[32]

In 1978, the Institute presented a supplement to "Our Future Selves" providing the reports of the three panels of specific research areas of the National Advisory Council on Aging—biomedical research, behavioral and social sciences research, and research on human services and delivery systems.

B. Biomedical Research

The National Advisory Council on Aging defines the goal of biomedical research on aging "to prolong the useful and active lives of the elderly and to raise the quality of their lives." [33]

The Council divides biomedical research into three categories: Basic biological aspects of aging, interaction of aging and disease, and interaction of aging and external influences.

---

[32] For a summary of the research plan, see "Developments in Aging: 1976," part 1, U.S. Senate Special Committee on Aging.

[33] "Our Future Selves," a research plan toward understanding aging, summary reports, panels on biomedical research, behavioral and social sciences research, and research on human services and delivery systems. National Advisory Council on Aging. U.S. Department of Health, Education and Welfare. DHEW Publication No. (NIH) 78–1446.

Basic aspects of aging addressed by the Institute include genetics of aging, mutation and repair of genetic material, ability of cells to synthesize and maintain key molecular components, maintenance and integrity of cellular organelles, cell function and loss, and physiological function and decline.

As to studies on the interaction of aging and disease, the Council points out that the Institute is in a "unique position to support research emphasizing the role of intrinsic aging in the interaction of aging and disease."[34] The Council lists several particularly significant areas, including senile dementia, cerebrovascular disease, cardiovascular disease, prostatic disease, menopause, renal diseases, endocrinopathies, osteoarthritis, osteoporosis, chronic lymphatic leukemia, breast cancer, hematologic disease, and response to infection.

External or environmental influences in the panel's summary include: Nutrition, drug metabolism, physical and chemical factors, experimental model systems for study of aging, study of human populations, and resources and training needs.

C. BEHAVIORAL AND SOCIAL SCIENCE RESEARCH

"The gain in life expectancy during the 20th century represents an achievement for modern industrialized societies, but it brings with it substantial changes in the society as a whole and enormous challenges for policymakers," according to the Council's report.[35] This trend toward longer life is leaving the country with two categories of older persons: the new-old, in their late 50's and 60's, and the old-old, in their 70's, 80's, and 90's. Each group represents different needs and problems and the Institute's efforts will have to address these differences. In addition, the Council warns that the programs developed for the new-old and old-old of today will most probably not apply to "future cohorts."

To meet the needs of the growing numbers of new-old and old-old persons, the Council describes the areas of research which the Institute is addressing:

(1) Research on how social, economic, and physical dependency can be reduced and prevented.

(2) Research on which specific personality, social, cultural, and environmental factors produce social competence and personal satisfaction in late life.

(3) Research on intergenerational relationships, on the changing roles of women, on how family networks may be changing as social resources for the older person, and on the role of the family in maintaining the old-old person as a member of the community.

(4) Research on the relationships among psychological, social, and physical aspects of health in middle and late life and on how health is related to socioeconomic status, ethnicity, rural-urban residence, and other social factors.

(5) Basic research to understand the observed differences between life expectancy between men and women, and methods of improving life expectancy of men.

---

[34] Reference cited in footnote 33.
[35] Reference cited in footnote 33.

(6) Studies on what we have learned from "natural" social experiments, such as medicare and medicaid programs, and their effects upon older persons, their families, and upon the health care system.

(7) Research on understanding how impairment is translated into functional disability, what social and biomedical factors are involved, and how the intellectual competence of middle age can be maintained.

(8) Research on how policies directed toward the aging and aged effect the aging and aged—for example, what is the effect of manpower and training programs on the employment of the aging and the aged?

Training of researchers should also be recognized as an integral part of the Institute's overall program plan. Professionals and students should be trained in the field of aging at all levels. The Council suggests that perhaps a modest goal should be sought—to increase the number of persons competent in aging research over the next 10 years in the same proportion as the increase in the number of persons aged 85 and over in the population, which could be nearly 50 percent.

D. Research on Human Services and Delivery Systems

The Council's summary proclaims that "research on human services and delivery systems overlaps the biomedical and behavioral/social fields, which produce the knowledge directly or indirectly applicable to the provision of services to the aging and aged." They compare services and the delivery system as "the bridge between biomedical-behavioral-social findings and the actual provision of services."[36]

According to the Council, research has not yet given us the adequate knowledge to design appropriate services and delivery systems. They indicate that the Institute will attempt to develop a more sufficient data base. Service programs and delivery systems across the board will be studied, including health services, mental health services, dental health services, nutrition and food services, physical environments impact, transportation, communication, legal services, commerce, education, social-emotional services, and economic support.

In addition to these specific services, data is needed about number and kinds of services, the adequacy of such services, the gaps in services, who is utilizing them, and the extent of utilization or underutilization.

V. ONE-YEAR INCREASE IN TITLE XX CEILING

The Revenue Act of 1978, signed on November 6, 1978, by President Carter (Public Law 95-600) included an amendment—added in the final weeks of the session—raising for 1 year the title XX social services program ceiling from $2.5 billion to $2.9 billion. Of that increase, $200 million is earmarked for child day care. Each State is to receive, at a 75-25 matching ratio, a share of the remaining, $200 million based upon its population. Decisions concerning how to allocate this increase will be determined by the States.

The new ceiling may prove to be temporary, since it is to apply to fiscal year 1979 only. If the Congress does not legislate future increases, the ceiling will revert back to the $2.5 level which had been effective since 1972 when the Congress mandated the ceiling because of escalation in the costs of social services programs.[37] In 1975, when the Congress enacted title XX, to replace the former social services program under title VI,[38] the legislators expanded the eligibility standards but retained the ceiling. Therefore, the States were forced to open up programs for more people with the same amount of funding, unless the State contributed more than its 25 percent share.

---

[36] Reference cited in footnote 33.

This concern grew as inflation took hold. Senator Daniel Patrick Moynihan, chairman of the Senate Finance Committee's Subcommittee on Public Assistance, described the situation in 1978:

> Title XX of the Social Security Act embodies the principal source of Federal support for social services. The expenditure ceiling for that important program has remained at $2.5 billion since 1972. Had it risen apace with inflation, it would now exceed $3.6 billion. It is little wonder that State and local governments, and other providers of these useful services, are now demanding an increase.[39]

The House of Representatives had responded earlier by approving a 3-year increase for title XX—$2.9 billion in fiscal year 1979, $3.15 billion in fiscal year 1980, and $3.45 billion for 1981.[40] In addition, the House provided for emergency shelter for adults under title XX (only shelter for children is now allowed), increased authorizations for the territories, required consultation between State and local officials prior to drafting of the State plan, and a multiyear planning option. All of these provisions and others died at the end of the 95th Congress. Instead, the Congress agreed to the tax bill amendment which provides for a simple 1 year increase.

The short history of title XX has also provoked much concern about who actually receives services, what kind of services are provided, and how title XX can be better coordinated with other service programs. The Senate Finance Committee included an amendment in the title XX reform bill to require the General Accounting Office to analyze the effectiveness of title XX, its cost benefits, and the capability of the State and Federal agencies to evaluate the program. This amendment was not acted upon.

When the Older Americans Act was under Senate consideration in 1978, a floor amendment was added to require the Secretary of Health, Education, and Welfare to conduct a study of the relationship of Older Americans Act programs and title XX. The study would center around methods of integrating and coordinating title XX and Older Americans Act programs in the planning process and the delivery of services. This amendment was deleted in the conference between the House and Senate.

GAO SURVEY

In 1978, Senator Frank Church requested the General Accounting Office to conduct a study of the use of title XX services by aged recipients of Supplemental Security Income (SSI). The GAO responded by examining title XX programs in seven States: Ohio, Pennsylvania, Florida, Maryland, Colorado, Mississippi, and New Mexico.

---

[37] Public Law 92-512 placed the $2.5 billion ceiling on the annualized Federal support for social services under the Social Security Act.

[38] Public Law 93-647 authorized a new social services program under the Social Security Act under title XX.

[39] Statement of Senator Patrick Moynihan, chairman of Subcommittee on Public Assistance, Senate Finance Committee, Aug. 8, 1978.

[40] H.R. 12973 was passed by the House of Representatives on July 25, 1978.

In December 1978, the GAO staff informed Committee on Aging staff of certain preliminary findings. GAO data shows that the needs of elderly SSI recipients are not being adequately met by title XX services. Reasons for the failure of title XX services to reach these persons vary from State to State but include poor outreach efforts, lack of planning and coordination among services and income maintenance agencies, and inadequate funding to satisfy all of the needs of the various interest groups who are served by title XX.

In the States surveyed, the GAO found that small proportions of the low-income elderly were receiving social services under the title XX program. The variation was great from State to State, ranging between 3 and 33 percent of each State's elderly SSI population receiving title XX social services

The GAO also found, however, that the need for services was great. More than 80 percent of those elderly SSI recipients who did not receive any title XX assistance had a need for one or more services.

The GAO found that 80 percent of the services received by elderly SSI recipients fall within 5 categories: homemaker/chore services, health services, transportation, counseling, and protective services. The GAO will recommend that the Department of Health, Education, and Welfare develop standards for the provision of in-home services for the States to use as guidelines.

Of the seven States examined, the GAO found that only Pennsylvania had a special earmarking of title XX funds for the elderly and only Pennsylvania had a formal coordinated effort between the Older Americans Act and title XX. The GAO will recommend that HEW encourage formal planning coordination and needs assessments for the Older Americans Act programs and title XX services. The final GAO study will be issued in April 1979.

VI. CRIME AND THE ELDERLY

Fear of criminal victimization remains a continuing problem for older Americans. While available statistics indicate that the elderly are less often the targets of crimes than younger persons, there is also a general consensus among authorities that:

—In some urban areas, low-income and minority elderly are disproportionately victimized.

—Criminal attacks have a more devastating impact upon the elderly. Physical injuries are slower to heal; great psychological distress results; and economic losses are difficult to recoup.

—A majority of older individuals limit their activities, resulting in a self-imposed isolation, due to apprehension about possible criminal assaults.

In 1978, the administration presented a sweeping proposal for the revision of anticrime funds disseminated to States and localities by the Law Enforcement Assistance Administration. Currently, LEAA provides money for a variety of anticrime programs benefiting older Americans.[41]

Two proposals which would have provided compensation to crime victims were approved by the Senate during the 95th Congress, but neither was passed in the House.

---

[41] A Dec. 22, 1978, letter from LEAA Deputy Administrator for Policy Development Henry S. Dogin, to Committee on Aging Chairman Frank Church, fully sets out these activities.

The National Committee on Crime and the Elderly continued its work during the year. However, the future course of the committee is uncertain due to questions about the availability and adequacy of Federal assistance in the coming year.

A. THE PROPOSED LEAA REORGANIZATION

The Law Enforcement Assistance Administration (LEAA) was established in 1968 to provide Federal assistance to States and localities for anticrime activities. In fiscal 1979, LEAA will distribute $641 million. Existing language in the Crime Control Act requires that each State's comprehensive plan for use of its LEAA funding provide for the development of programs and projects for the prevention of crime against the elderly.

On July 10, 1978, President Carter proposed a major overhaul of LEAA activities, and a reorganization of Justice Department responsibilities in "The Justice Department Improvement Act of 1978." [42] This legislation, developed with the assistance of Senator Edward Kennedy and Representative Peter Rodino, would:

—Reauthorize LEAA for 4 years, at an annual funding level of approximately $825 million.

—Simplify the process by which LEAA funds are distributed to States and localities, and substantially reduce related paperwork.

—Require that State plans be filed in the agency only once every 3 years, in contrast to the present requirement of annual submissions. Seventy percent of LEAA funds would be distributed without "strings," in the same manner as general revenue sharing moneys, although prohibitions would be enacted against the use of the Federal assistance for equipment and hardware construction general salary increases, excessive administrative costs, and programs which have not demonstrated their effectiveness.

—A new funding formula would take crime rates into account, and would guarantee fixed allocations of funds to municipalities with populations of more than 100,000 persons, and counties exceeding 250,000. However, the new legislation specifies that no city or State would lose money under this new formula.

—Increase participation of community and neighborhood organizations in determining the use of Federal anticrime assistance through required public hearings and representation on State and local advisory boards.

—Establish a new National Institute of Justice within the Justice Department, to conduct anticrime and justice system improvement research, together with a new Buretau of Justice statistics, for the collection of data on criminal and civil justice matters, and their analysis and dissemination.[43]

---

[42] The President's message to Congress, July 10, 1978.

[43] The suspension of LEAA's national crime survey prevented the publication of new nationwide statistics on criminal victimization by age; the most current available data, for 1974–75, is reprinted in "Developments in Aging: 1977," part 1, pp. 193–5. New data made available by the SCAN (Senior Citizens Anti-Crime Network) in New York City is encouraging. During 1977, in comparison to 1976, the total number of crimes against the elderly reported to the New York police declined by nearly one-quarter. The elderly victimization rate was 5 to 10 times less than that for the city population as a whole. Street robberies continue to be the most common crime perpetrated against older persons, with the average victim being an older woman 69 years old and the average offender a male 20 years old. Thirty percent of those persons charged with the most common offenses committed against the elderly in 1977 were juveniles of less than 16 years old. SCAN Bulletin No. 5, March/April 1978, 150 Nassau Street, New York, N.Y. 10038.

—Found a new Office of Justice Assistance, Research, and Statistics to designate "national priority grants" to proven anticrime programs, and to coordinate the activities of LEAA and the other two new entities.

Hearings on this proposed reauthorization and reorganization were conducted by the Senate Subcommittee on Criminal Laws and Procedures in August 1978, and additional hearings may be conducted in the first part of 1979. Attorney General Griffin Bell, testifying at the initial hearing, said:

> The current statute imposes about 25 broad requirements regarding plan content upon States. Implementation of these requirements has resulted in annual State plans of extraordinary length. In 1977, they totaled over 50,000 pages. . . . Despite this massive and costly effort, planning in many States has been more ritual than reality—focusing to a large degree on statutory compliance. . . . Enactment of the administrations' bill will reverse this trend. Statutorily mandated requirements will be reduced from 25 to 8.

Under the administration proposal, the existing requirement that State plans provide for projects to reduce elderly victimization would be one of those eliminated. However, the proposed increased participation of community groups and neighborhood organizations in specifying the use of Federal anticrime dollars, and expansion of the community anticrime program was expected to provide older persons and their advocates with a means of assuring that this priority is not overlooked.

Both Houses of Congress must report legislation to reauthorize LEAA by May 15, 1979, in compliance with the congressional budget process, and such legislation must be enacted and become law by October 1 of the LEAA, in whatever form, is to continue.[44]

B. Victim Assistance Defeated in House

Two Senate-passed measures which would have made new resources available for the compensation of the victims of violent crime were defeated in the House of Representatives during 1978.

S. 1437, a comprehensive revision of the Federal Criminal Code, was approved by a 72 to 15 Senate vote in January. Included in this recodification was the establishment of a new fund for the compensation of victims of Federal crimes of bodily violence, or their survivors. Awards of up to $50,000, and emergency compensation of up to $1,500, was permitted under the Senate bill. However, the membership of the House Subcommittee on Criminal Justice, after a month-long review of the legislation, issued a unanimous statement that the omnibus approach to Criminal Code revision favored by the Senate and the Department of Justice was "undesirable." [45] Instead, the subcommittee filed a much less extensive bill for consideration by the House (H.R. 13959), which was rejected by that body on October 4, 1978.

---

[44] At the same time at which he announced the proposed reorganization of LEAA, the President also noted that he was reprograming $200 million in appropriated funds for the rehabilitation and improvement of physical security in 50 to 60 large public housing projects. Washington Post, July 11, 1978, p. A4; New York Times, July 11, 1978. The 1978 Housing Act also contains $12 million for 1-year demonstration projects to improve crime prevention within public housing. Further details can be found in chap. VIII of this report.

[45] National Journal, Aug 26, 1978, p. 1374.

Most criminal offenses committed against the elderly, however, are State and local rather than Federal offenses. In 1977, the House passed legislation which would have extended Federal assistance to State victim compensation programs meeting certain minimum requirements (H.R. 7010). Corresponding legislation (S. 551) was approved by the Senate on September 11, 1978, containing additional language permitting States to waive a $100 "deductible" provision for victims age 62 and over, and encouraging the States to establish emergency compensation procedures for elderly victims. Committee on Aging Chairman Frank Church, in floor remarks, said:

> . . . criminal victimization—even though the resultant personal injury loss may be small—may have a devastating financial impact for older Americans struggling on limited income. A $50 loss, for example, may result in unpaid utility bills, unfilled prescriptions, or missed meals. . . . Many older Americans live under a form of house arrest becaue of fear of criminal victimization. To the extent that a Federal contribution can encourage the establishment and expansion of victims compensation programs, it can help to reduce this fear by letting the elderly know that a criminal attack need not result in crippling financial losses. . . . Immediate aid is often essential for the traumatized older person. Fourteen States already provide immediate assistance . . . the program has two beneficial effects: First, to give direct and immediate help, and second, to see that the State compensation program is functioning properly for older victims.[46]

Senate and House conferees subsequently agreed to a compromise bill which included both Senate provisions concerning elderly victims, and which would have reimbursed States for one-quarter of the first $35,000 awarded to victims provided that the State program met minimum Federal criteria. The conference report was adopted by a voice vote in the Senate on October 15. However, that same day, the House rejected the conference report by a vote of 199 to 184. The apparent reason for this reversal was the raising of the 3-year authorization for assistance to $120 million, compared to the $90 million originally approved by the House.

Similar legislation is expected in the 96th Congress. Meanwhile, as of July 1978, 25 State programs were distributing a total of more than $17 million per year for victims' compensation. However, a recent survey of these programs strongly questions their effectiveness as presently structured.[47] That study found:

> Despite the expenditure of these funds, the ambitious goals of victims' compensation have not been realized. . . . The failure to compensate more victims is primarily attributable to the inherent limitations in the laws and program characteristics, and not to any lack of concern among administra-

---

[46] Congressional Record, Sept. 11, 1978, p. S14930.

[47] "Victim Compensation and the Elderly: Policy and Administrative Issues," by Richard Hoffrichter, research associate, criminal justice and the elderly program, legal research and services for the elderly, National Council of Senior Citizens, September 1978.

> tors. . . . Under existing legislation in all States, only a narrow class of victims . . . are eligible for reimbursement. Even if one accepts that definition of the eligible class, only a very small percentage of the intended beneficiaries ever learn about the existence of the programs.[48]

This comprehensive survey found that four central problems reduced the effectiveness for the elderly of compensation programs:

- —Insufficient staff and monetary resources result in a low public awareness of program existence and benefits.
- —Legislative exclusions—including "means tests," denial of awards for injuries inflicted by family or household members, minimum loss requirements, universal exclusion of compensation for property and monetary losses, and lack of provision for emergency awards—all work to deny benefits to elderly victims or discourage their participation in the program.
- —Administrative "redtape" and delay also discourage participation and deny benefits when they are most needed.
- —Lack of personalized and sensitive outreach results in older persons being unable to deal effectively with compensation program and the criminal justice system.

The conference version of the Victims of Crime Act of 1978 would have addressed several of these shortcomings, and these findings may well be considered by the Congress if further attempts are made to provide Federal assistance to State programs on the proviso that they meet minimum national standards.

C. ACTIVITIES OF THE NATIONAL COMMITTEE ON CRIME AND THE ELDERLY

The national committee began its second full year of operations in 1978.[49] Its national coordination project is continuing its oversight of seven model projects, and has more fully developed its research, policy, and information dissemination functions. The model projects are in the process of institutionalizing and expanding activities on a citywide basis, while also providing greater information and technical assistance resources. In particular, they hope to devote more attention to crisis intervention and "neighborhood strengthening" through community anticrime efforts. However, funding for all projects expires during the spring-summer of 1979, and it is not yet clear whether the Federal agencies involved will make funds available for the third and final year of project activity.[50]

The national committee, which was instrumental in helping Senate supporters insert special language in S. 551 for the benefit of older crime victims, will seek action on its Federal victims compensation assistance in the 96th Congress, including provisions for "elderly emergency assistance units," at the local level, to help elderly victims deal with the physical, psychological, and financial traumas associated with being the target of violent crime.[51]

---

[48] Ibid., p. 1.

[49] For further background on the organizational makeup, history, and goals of the committee, see "Developments in Aging: 1977," pp. 197–8.

[50] Conversation with John Stein, deputy director, National Committee on Crime and the Elderly, Dec. 29, 1978. Of the four Federal funding agencies (HUD, LEAA, Community Services Administration, and AoA), only HUD has indicated that it expects to be able to provide third-year funding at present levels.

VII. EDUCATION PROGRAMS FOR THE OLDER ADULT

The National Institute on Aging's Advisory Council on Aging states that there are two kinds of education in the field of aging: (1) Education for improving the delivery of human services to the aged, and (2) education throughout life as a human service to our society.[52] This section will describe the efforts in the later type—those educational programs for the older adult.

Scattered throughout the Federal departments and agencies are educational and training programs for older persons. Some develop new and improved skills for the aging person while others provide entertainment and stimulation of the mind. Both are important and both have been shown to keep the person more active and more alert.

According to the lifelong learning study mandated by the Congress,[53] approximately 50 programs perform functions which serve older adults in educational opportunities.[54] Many are administered under the Office of Education, the Administration on Aging, the ACTION agency, and the Department of Labor.

The Office of Education supports an array of basic education programs for older persons. For example, elderly participate in many of the programs offered under occupational adult education. Title I of the Higher Education Act has funded several programs ranging from teaching aging adults about skills needed for seeking employment to courses in arts and crafts which utilize seniors with special talents to keep alive some of the dying forms of art.

The Fund for the Improvement of Postsecondary Education in the Department of Health, Education, and Welfare has funded projects at institutions of higher education. For example, the fund supported a United Auto Workers' retired and older workers program in Michigan to assist in providing pre- and post-retirement training to its nonmanagement employees. In New Hampshire, the fund has supported a pioneer program at New England College to allow older persons to attend standard academic courses which are structured for 2 weeks or in modular form. Some of the participants became campus residents. A training team was supported in Minnesota to travel from campus to campus training staff and faculty in programs for older persons and intergenerational courses.

---

[51] Comprehensive research on the sociological, economic, and psychological impact of crime on the elderly is being conducted by the University of Miami Institute for the Study of Aging and the Department of Applied Social Sciences. With funding provided by the Administration on Aging, the research will seek out answers regarding the impact, over a period of time, on the elderly individual whose life may become more restricted and frightening as a result of victimization. Local police officials are cooperating both with the research project and in educational activities to make law enforcement personnel more cognizant of the aging process. (From "Aging Update," Institute for the Study of Aging, University of Miami, Coral Gables, Fla., November 1978.)

[52] "Our Future Selves," a research plan toward understanding aging, summary reports on biomedical research, behavioral and social sciences research, research on human services and delivery systems, National Advisory Council on Aging, National Institute on Aging, National Institutes of Health, Department of Health, Education, and Welfare, DHEW Publication No. (NIH) 78–1446.

[53] "Lifelong Learning and Public Policy," a report prepared by the lifelong learning project, Education Division, Health, Education, and Welfare, February 1978.

[54] For a description of lifelong learning, see part C of this section.

The Administration on Aging has funded several education programs for the elderly in the past. However, in 1978 the model projects award listed only one educational demonstration project: a "community-based learning center for older adults" at the University of Wisconsin. It brings education to the older student in a senior center, housing project, nutrition center, or day care center.

A. Community Education

Community education grants are made to State and local educational agencies to support programs for all age groups in local neighborhood schools. In sponsoring legislation to extend community education programs, Senator Frank Church said:

> As chairman of the Senate Committee on Aging, I have witnessed the successful teamwork among community schools, senior centers, and our older Americans. Such cooperation with aging programs builds bridges of communication and interests throughout the community.[55]

A small program in the past, community education (under the Office of Education) received increased authorizations and status under the Elementary and Secondary Education Amendments of 1978 as a new title VIII.[56]

B. Other Programs

Another expanding program is Elderhostel. With the support of The Fund for Post-Secondary Education (HEW) and other Federal grants in the past, and growing private support and tuitions, Elderhostel programs have spread to 40 States and approximately 230 colleges and universities. Elderhostel, which began at the University of New Hampshire in 1975, is a higher education program for persons 60 and over who are housed on campus and participate in weeklong academic programs during the summer. The students have a choice of classes and universities and an opportunity to experience campus life and interaction with younger students at close hand.

Private foundations and organizations have demonstrated an increasing interest in learning programs for the older person in the last few years. The American Association of Community and Junior Colleges in Washington, D.C., has established an older Americans program which assists its member colleges with information and materials about programs for the aging person. AACJC also maintains a lifelong learning program which oftentimes overlaps with the activities of the older Americans program.

The Academy for Educational Development in New York has maintained a program for aging for several years. This program has been responsible for leading the academy's efforts for programs for the older student including the publication of "Never Too Old to Learn" and "Never Too Old to Teach" These publications, which were widely distributed to educational institutions and organizations, described older persons and their needs and the types of programs which can benefit them.

---

[55] Statement of Senator Frank Church upon sponsoring the Community Schools and Comprehensive Education Act of 1978 (S. 2711), Mar. 20, 1978.

[56] Public Law 95-561, enacted Nov. 1, 1978.

A new program was begun in 1978 to monitor and disseminate information on how organizations can use the skills and talents of older persons. Elderworks, Inc., in New York issues a newsletter and other publications describing successful approaches to utilizing the talents of older persons and encourages further development of these approaches and others. Elderworks does not operate a program but concentrates its efforts on informing other employers about the potentials of the older person.

C. LIFELONG LEARNING

Two years ago, the Congress included a study project within the Higher Education Act Amendments of 1976 which directed the Office of Education to establish a Office of Lifelong Learning.[57] This Office would be responsible for identifying all educational, training, volunteerism, and employment efforts of Federal agencies which could be classified as lifelong learning. The Office of Lifelong Learning was required to report its findings to the Congress with its recommendations for improving or coordinating lifelong learning efforts.

The Lifelong Learning and Public Policy report was presented to the Congress in February 1978. The report defines lifelong learning as "the process by which individuals continue to develop their knowledge, skills, and attitudes over their lifetimes." This process is offered through a variety of "learning opportunities" which, as indicated earlier, are not limited to the traditional educational programs, but also include training, employment, volunteerism, and other learning opportunities.

The report points out the growing population of persons 65 and over, who are in better health and living longer. However, the older population's participation in educational or lifelong learning programs is considerably lower than other interest groups.

What obstacles do they encounter? At hearings on "Work, Retirement, and Lifelong Learning," Senator Frank Church asked:

> Now that the end of mandatory retirement is in sight, isn't educational opportunity in later years even more important, not only as a means of adapting to new work demands and making oneself a continuing valuable employee, but also as a way of adjusting to new interests when work hours decrease or, at an agreed-upon date, end entirely?[58]

Traditional barriers to learning by older persons include the biases toward the young in education programs, financial aid policies, and the overall philosophy of education. Other problems include: Inadequate transportation, limited incomes, scheduling of programs, unfamiliarity with classroom structures and campus routines, and overall unawareness of the opportunities. According to the lifelong learning study:

> "Perhaps the most formidable barrier is the one cited by the 45 percent of those 65 and over who were surveyed by the National Council on the Aging. Quite simply, they were not interested.[59]

---

[57] Public Law 94-482.

[58] Opening statement of Senator Frank Church at hearings on "Work, Retirement, and Lifelong Learning," Senate Special Committee on Aging, July 17, 1978.

[59] Harris and Associates Poll for the National Council on the Aging, 1975.

A change in society's concept of education as an important component of lifelong learning is urged in the study, which adds:

> Since human learning takes place within the context of social life, it is always possible to ask whether the social arrangements of everyday life inhibit or enhance learning opportunities that may lead to the enrichment of individual, human experience.

VIII. EMPLOYMENT

In many respects, 1978 was one of the most productive years for middle-aged and older workers—not only in terms of concrete action, but also innovative developments.

The 1978 Age Discrimination in Employment Act Amendments [60] abolish mandatory retirement for practically all Federal workers.[61] The new law also prohibits mandatory retirement before age 70 for covered workers in private employment and State and local government employees.[62]

An Age Discrimination Act, enacted into law as a part of the 1978 Older Americans Act,[63] offers the prospect of increased jobs and training for unemployed or underemployed older Americans.[64]

Congress reaffirmed its support for the senior community service employment program [65] by substantially enlarging it over a 3-year period. Congress also voted to expand flexitime [66] and part-time employment [67] opportunities in the Federal Government.

A. COMPREHENSIVE EMPLOYMENT AND TRAINING ACT AMENDMENTS

CETA, the Nation's primary jobs and training program, underwent major changes in 1978, with potentially far-reaching implications for middle-aged and older workers. Shortly before adjournment, Congress approved a 4-year extension of CETA.[68]

A restructured title II directs comprehensive employment and training services to the economically disadvantaged.[69] Funds authorized for title II are available for two distinct programs. Parts A, B, and C include a wide range of employment and training services for the economically disadvantaged: Job counseling, skill training, work experience programs, on-the-job training, and many others.

Part A establishes a transitional public service employment program for economically disadvantaged persons. These jobs will be coupled with appropriate training and supportive services to enhance the future employment prospects of participants. The new law directs the Secretary of Labor to insure that prime sponsor's plans for serving older workers include provisions for coordinating services with those provided by senior centers, area agencies on aging, and State agencies on aging.

---

[60] Public Law 95–256, approved Apr. 6, 1978.

[61] Public Law 95–256 abolishes mandatory retirement, effective Sept. 30, 1978, for about 95 percent of all Federal employees. Persons engaged in hazardous jobs—such as firefighters or law enforcement officials—are not affected by the provision to eliminate mandatory retirement.

[62] This provision becomes effective Jan. 1, 1979.

[63] Public Law 95–478, approved Oct. 18, 1978.

[64] The Age Discrimination Act prohibits discrimination on the basis of age concerning any program or activity receiving Federal financial assistance.

[65] The senior community service employment program was extended as a part of the Comprehensive Older Americans Act Amendments of 1978, Public Law 95–478, approved Oct. 18, 1978.

[66] Public Law 95–390, approved Sept. 29, 1978.

[67] Public Law 95–437, approved Oct. 10, 1978.

[68] Public Law 95–527, approved Oct. 24, 1978.

[69] For purposes of title II, an "economically disadvantaged" person in an individual who receives public assistance or has or is a member of a family with total income (exclusive of welfare and unemployment compensation) not exceeding the poverty level or 70 percent of the lower living standard income level, whichever is higher.

Title III authorizes special national programs and activities for several groups, and includes several provisions for middle-aged and older workers (persons 55 or older) based upon legislation sponsored by Senators Chiles and Domenici and Representative Waxman. Public Law 95–527 directs the Secretary of Labor to:

—Establish programs and policies to enable middle-aged and older workers to obtain a more equitable share of employment and training resources.

—Facilitate the transition of workers over 55 years of age from nonparticipation to participation in the labor force, including work experience, vocational education, public service employment, on-the-job training, occupation upgrading, job placement, and technical assistance to employers to establish flexitime, job sharing and other innovative arrangements.

—Conduct research on the relationships between age and employment.

—Establish programs to increase labor force participation by older workers who are able and willing to work but are unable to secure work or are discouraged from seeking employment.

A special program to provide employment opportunities and supportive services is also established for displaced homemakers. Older women are expected to be among the major beneficiaries of the training and supportive services—including job training, job readiness services, job counseling, job search, job placement services, and information on education opportunities—since they represent a sizable number of all displaced homemakers in the United States. A major emphasis of the program is to create new jobs in the private sector.

Title VI establishes a countercyclical employment program to provide public service jobs for the long-term unemployed [70] and public assistance recipients (including persons receiving supplemental security income payments) who are out of work because of an economic downturn.

B. SENIOR COMMUNITY SERVICE EMPLOYMENT

Congress approved a major expansion of the senior community service employment program as a part of the 1978 Older Americans Act Amendments.[71] This program provides jobs in a wide range of community service endeavors—such as hospital aides, beautifying the countryside, handyman jobs, and many others—for low-income persons 55 or older. The new law authorizes $1.2 billion for the older

---

[70] Participants must be unemployed for at least 10 of the 12 weeks immediately prior to determination of eligibility. In addition, their income for the preceding 3 months (when annualized) must not exceed the lower living standard income or their family must receive AFDC or SSI benefits.

[71] The senior community service employment program was redesignated as title V of the Older Americans Act; Public Law 95–478, approved Oct. 18, 1978.

American community service employment program over a 3-year period: $350 million for fiscal 1979, $400 million for fiscal 1980, and $450 million for fiscal 1981.

Approximately 47,500 persons now participate in the national senior service corps. If fully funded, the program would provide about 75,000 jobs in 1979, 81,000 in 1980, and 88,000 in 1981.

Other important changes in the new legislation include:

- Persons with incomes not exceeding 125 percent of the poverty guidelines can work as senior aides. The effect is to allow the marginally poor to participate in the program.[72]
- National contractors must submit a description of a senior community service employment project to the appropriate State agency at least 30 days prior to the project's starting date.
- National contractors will be authorized to retain at least the number of jobs supported during fiscal year 1978. Additional funding after 1978 will be allocated at 55 percent for the States and 45 percent for the national contractors.
- The Secretary of Labor is directed to develop innovative work modes and provide technical assistance in creating job opportunities through work sharing and other experimental methods to prime sponsors, unions, and employers.
- The Department of Labor is directed to reserve up to 1 percent of appropriations above the fiscal 1978 level in order to enter into agreements to improve the transition from the senior community service employment program to private employment.
- The Secretary of Labor is authorized to fund and expand a Senior Environmental Employment Corps.

C. TITLE X OLDER WORKERS PROJECTS

A stopgap funding resolution for fiscal 1979 [73] continued 71 older worker projects originally funded by the Administration on Aging under the title X job opportunities program of the Public Works and Economic Development Act. The resolution directs the Department of Labor to use CETA funding to continue about 4,700 jobs for workers 50 or older in a wide range of capacities benefiting their communities, including environmental aides, parks and recreation aides, home health

---

[72] See following table:

POVERTY LEVELS (125 PERCENTUM) FOR ALL STATES: ANNUAL FAMILY INCOME

Family size	Continental United States		Alaska		Hawaii	
	Nonfarm	Farm	Nonfarm	Farm	Nonfarm	Farm
1	3,925	3,362	4,925	4,225	4,525	3,912
2	5,200	4,437	6,512	5,563	5,987	5,137
3	6,475	5,512	8,099	6,901	7,449	6,362
4	7,750	6,587	9,686	8,239	8,911	7,587
5	9,025	7,662	11,273	9,577	10,373	8,812
6	10,300	8,737	12,860	10,915	11,835	10,037

Note: Income limits for families of more than 6 persons are determined by adding for nonfarm and farm levels these amounts for each additional family member: Continental United States: $1,275 nonfarm and $1,075 farm; Alaska: $1,587 nonfarm and $1,338 farm; Hawaii: $1,462 nonfarm and $1,225 farm.

[73] Public Law 95-482, Oct. 18, 1978.

aides, nutritional aides, legal services aides, ombudsmen, and preretirement counselors. The Senate Appropriations Committee report emphasized that older workers meeting the qualifications for the title V senior community service employment program should be transferred at the earliest possible date.[74] Title V provides part-time jobs for low-income persons 55 years or older. The title X job opportunities program applies primarily to persons 50 or older. In addition, it provides full-time employment as well as part-time jobs for older workers.

D. Flexible and Compressed Work Schedules Act

President Carter signed into law (Public Law 95–390) on September 29 the Federal Employees Flexible and Compressed Work Schedules Act, which is designed to promote innovative work arrangements for Federal employees. Public Law 95–390 establishes a 3-year experimental program to test the expanded use of flexible and compressed work schedules in the Federal Government. A compressed work schedule permits full-time employees to work less than 10 working days during an 80-hour biweekly basic work period. Individuals, for example, can work 10 hours a day for 4 days a week.

Flexitime permits workers to alter the standard 9 to 5 workday to accommodate personal needs or preferences. It is expected to be most helpful for older workers, handicapped individuals, and persons with child care responsibilities.

Persons participating in flexitime or compressed work schedules programs are still subject to the same number of hours and other regulations that Government agencies establish for other employees. The General Accounting Offices estimates that 10,000 private sector organizations with 1.2 million workers are using compressed work schedules, and 300,000 to 1 million private employees are employed on a flexitime basis.

E. Federal Employees Part-Time Career Employment Act

Another potentially important legislative development for older workers is the Federal Employees Part-Time Career Employment Act (Public Law 95–437). In recent years the number of part-time employment opportunities in the private sector has increased markedly. About one out of every six workers in private employment—or 17 percent—is now working part-time.[75] Public Law 95–437 is designed to promote part-time employment in the Federal Government by authorizing the Civil Service Commission to: (1) establish a part-time employment program, (2) provide technical assistance to agencies, and (3) report annually to the Congress on part-time hiring by Government agencies. Older persons are expected to be among the principal beneficiaries of the legislation, since many prefer part-time employment to provide (*a*) an alternative to retirement or (*b*) additional income to supplement retirement benefits.

---

[74] Continuing appropriations, 1979. S. Rept. 95–1317 to accompany H.J. Res. 1139, 95th Cong., 2d sess., Oct. 11, 1978, p. 4.

[75] Federal Employees Part-Time Career Employment Act of 1978, H. Rept. 95–932 to accompany H.R. 10126, 95th Cong., 2d sess., Mar. 8, 1978, p. 2.

F. AGE DISCRIMINATION IN EMPLOYMENT AMENDMENTS OF 1978 (PUBLIC LAW 95–256)

The Age Discrimination in Employment Amendments of 1978 make potentially far-reaching changes affecting mandatory retirement policies and practices.

The new amendments will eliminate mandatory retirement for most Federal workers and prohibit mandatory retirement for most public and private workers before age 70 as of January 1, 1979.

Coverage under the new law does not extend to non-Federal employees over the age of 70.

Among the other significant exemptions are:

- The employer demonstrates that age is a bona fide occupational qualification. For example, Federal air regulations provide that an airline may not allow a flight crew member to fly as pilot in command after age 60.
- Employees who for 2 years prior to retirement occupy an executive or high policymaking position and are entitled to annual retirement income, excluding social security, of at least $27,000.
- Tenured college and university faculty members may be mandatorily retired at age 65 until July 1, 1982, when the mandatory retirement age is increased to 70 for them.
- Persons who are covered by a bona fide collective bargaining agreement in effect on September 1, 1977, may be mandatorily retired at age 65 until January 1, 1980, or until the agreement expires, whichever is later.

The new legislation also requires the Secretary of Labor to conduct a study on the effect of raising the upper age limitation to age 70 and the feasibility of raising the limitation above that age. This study—due to be presented to the President and Congress by January 1, 1982, with an interim report submitted by January 1, 1981—will also make recommendations on the effect of the bona fide executive and tenured faculty exemptions.

One of the new amendments is the revision of section 4(f)(2) which deals with the structure and management of the employee benefit plans.

Landmark age discrimination litigation involving interpretations of congressional intent regarding involuntary retirement resulted from the original construction of this section which, when enacted in 1967, stated:

> It shall not be unlawful for an employer, employment agency, or labor organization . . . to observe the terms of a bona fide seniority system or any bona fide employee benefit plans such as retirement, pension, or insurance plan which is not a subterfuge to evade the purposes of this act, except that no such employee benefit plans shall excuse the failure to hire any individual.

According to Members of Congress, the original intent of this wording was to make clear that employers should not be discouraged from hiring older workers because of any requirement that would bear increased benefit costs afforded younger workers.[76]

---

[76] For a complete discussion of the legislative history of the Age Discrimination in Employment Act, see The Next Steps in Combating Age Discrimination in Employment: With Special Reference to Mandatory Retirement Policy, a working paper prepared for use by the Special Committee on Aging by Dr. Marc Rosenblum, 1977.

In *McMann* v. *United Airlines* (1977), the first age discrimination case to reach the Supreme Court, it was held that a company could terminate an employee in accordance with pension plan terms instituted in good faith before the passage of the Age Discrimination in Employment Act of 1967.

The 1978 amendments modify section 4(f)(2) by adding:

> . . . and no such employee benefit plan shall require or permit the involuntary retirement of any individual specified by section 12(a) of this act because of the age of such individual.

Representative Augustus F. Hawkins, a member of the House-Senate Conference Committee on the amendments, explained:

> . . . the purpose of this amendment is to make absolutely clear that this exception does not authorize an employer to require or permit involuntary retirement of an employee within the protected age group on account of age. . . . The purpose of section 4(f)(2) is to encourage the employment of older workers by permitting age-based variations in benefits where the cost of providing the benefits to older workers is substantially higher. Any age-based differences in benefits would have to be evaluated under the standard section 4(f)(2).[77]

The establishment of fair benefit cost differentials for older worker employee benefits plans is expected to be crucial to employee benefit plan sponsors as they undertake to conform benefit plans and personnel policies to the requirements of the new law.

The Department of Labor issued an interpretive bulletin on the establishment of these differentials on September 22, 1978. The Department conducted a hearing to receive comments on the proposed interpretations on October 23.

Additional interpretive bulletins are scheduled on the subject of involuntary retirement, and the exemptions of the act with respect to executive and policymaking employees and tenured faculty members.

TRANSFER TO EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

An Executive order implementing the President's Reorganization Plan No. 1 of 1978, transferred day-to-day enforcement of the overall act from the Wage and Hour Division of the Department of Labor to the Equal Employment Opportunity Commission. This transfer is scheduled for completion by July 1, 1979.

G. Humphrey-Hawkins: The Full Employment and Balanced Growth Act of 1978 (Public Law 95–523)

Originally designed as a detailed action plan to coordinate economic policy in order to make a comprehensive attack on unemployment, the Humphrey-Hawkins bill emerged in the latter days of the 95th Congress as a goal-setting proposal.

As a statement of national policy regarding unemployment and balanced growth, this measure directs special attention to middle-aged and older workers in actions taken to reduce unemployment in accordance with the act's broad goals. The act requires the President to:

---

[77] Congressional Record, Mar. 21, 1978, p. H2270.

> . . . transmit to the Congress during the first 20 days of each regular session . . . an economic report together with the annual report of the Council of Economic Advisers submitted in accordance with section 11(c) of this act, setting forth employment objectives for certain significant subgroups of the labor force, including youth, women, minorities, handicapped persons, veterans, and middle-aged and older persons.[78]

Unemployment for persons 45 and older typically ranges from 19 to 21 percent of the total unemployment; middle-aged and older workers ordinarily account for approximately 25 to 33 percent of the total long-term unemployment.

This act sets an unemployment goal of 4 percent by 1983, along with the anti-inflation goals of a 3-percent rate by 1983 and zero by 1988. It also calls for a balanced budget, a trade surplus, and higher price supports for farmers.

Additionally, it requires the President, the Congress, and the Federal Reserve Board to set forth their economic goals and policies each year to achieve the broad purposes of the act. There are no requirements for either executive or congressional action should these policies fall short of their goals.

IX. NEW ACTIONS ON PENSIONS

Mounting concern about shortcomings in national retirement policy [79] has focused new attention on private pension issues. A Presidential reorganization plan offered in 1978 was intended to provide an interim framework for regulatory improvement. New analyses of pension issues, however, called for additional corrective action. The Supreme Court, by deciding to take a controversial pension case in one instance and handing down a decision related to women's rights in another, also contributed to the national pension discussion.

A. ERISA REORGANIZATION AND OTHER CHANGES

The Employee Retirement Income Security Act of 1974 established minimum standards, protection, and disclosure requirements for private pension systems. Implementation has been hampered, however, by a number of difficulties, including delays in issuing regulations and administrative decisions, due to the dual jurisdiction shared by the Departments of Labor and Treasury under the act.

On August 10, 1978, President Carter issued Reorganization Plan No. 4, which took effect 60 days later. In his message the President said:

> ERISA was an essential step in the protection of worker pension rights. Its administrative provisions, however, have resulted in bureaucratic confusion and have been justifiably criticized by employers and unions alike.

---

[78] Public Law 95-523, approved Oct. 27, 1978.

[79] The committee's hearings on retirement policy are described fully in chapter I.

The Reorganization Plan provides:

—The Treasury Department is given statutory authority for setting minimum standards for pension plan funding, and employee participation and vesting of benefit rights. The Department of Labor, however, retains a veto right over Treasury decisions which significantly affect plans established through collective bargaining.

—The Department of Labor is given statutory authority for setting the fiduciary obligations of pension trustees, to assure that instances of conflict of interest and management abuse do not occur.

—Both Departments retain enforcement powers, with Treasury empowered to audit plans and levy tax penalties and Labor authorized to bring civil court actions against plans and trustees.

While the plan is expected to improve ERISA's administration, and to cut processing times and paperwork,[80] it is only a temporary arrangement. The Office of Management and Budget will evaluate the experience of both Departments under this division of jurisdiction and, by April 30, 1980, the administration will present the Congress with legislative proposals for permanent changes.[81]

The Congress continued to examine other aspects of ERISA. The Senate Committees on Finance and Human Resources held 3 days of joint hearings in August 1978 on seven legislative proposals for improving the act. In testimony presented at that inquiry, Committee on Aging Chairman Frank Church emphasized the need for improving the private pension system:

> The increased longevity of the American population, the national trend toward earlier retirement, fiscal strains on the social security system, and the recent enactment of the Age Discrimination Employment Amendments of 1978 point up the need for a strong and equitable private pension system. . . . The Committee on Aging stands ready to make its contribution to the congressional consideration of pension issues by supplying data on the broad societal transformations which must necessarily impact on the form and adequacy of the private pension system. The soundness of the private pension system is second only to the fiscal integrity of social security in our joint objectives of guaranteeing security in retirement and expanding work and retirement options for all Americans.

---

[80] An Apr. 27, 1978, GAO report on the "Effect of the Employee Income Retirement Security Act on the Termination of Single Employer Defined Benefit Pension Plans" (HRD-78-90) found that "the act did contribute greatly to pension plan terminations" but "the adverse effect on American workers indicated by the number of terminations is misleading" because: (a) termipating plans generally did not meet the act's minimum participation and vesting requirements; (b) participants in terminated plans received almost all their vested benefits; and (c) 40 percent of the sponsors of terminated plans continued pension coverage for their workers through new means, and additional workers set up individual retirement accounts. The GAO also found that all of the agencies with administrative duties under the act had made progress in issuing guidelines and reducing paperwork; and that the act's provisions should "strengthen responsible management of new and continuing plans and give tens of millions of workers a better chance to earn and receive vested benefits without having to work an unreasonable number of years."

[81] In testimony before the Senate Governmental Affairs Committee on Sept. 7, 1978, Harrison Wellford, Executive Associate Director of OMB, stated: "We will consult closely with Senators and Members of Congress who have an interest in ERISA administration in this process of designing and implementing the evaluation, and analysing other options—including the single-agency approach contained in S. 3017 sponsored by Senators Williams and Javits, and the division or jurisdiction approach contained in S. 2352 sponsored by Senator Bentsen."

CONCERN ABOUT MULTIEMPLOYER PLANS

Of the 35 million American workers who are covered by ERISA's protections, about 8 million are participants in multiemployer pension plans.[82] In 1977, the Pension Benefit Guaranty Corporation (PBGC)—the agency established by ERISA to provide insurance to employees against the loss of benefits resulting from pension plan termination—alerted the Congress that these plans faced major problems. In response, the Congress deferred mandatory coverage of multiemployer plans by PBGC until July 1, 1979, and ordered the Corporation to submit a further report on the situation.[83]

That report,[84] issued on July 1, 1978, found that about 10 percent of multiemployer plans, covering 15 percent of participants in such plans (1.3 million workers), were experiencing financial difficulties that could result in plan termination within 10 years. If all of these plans were to terminate, the cost which would have to be covered under the present termination insurance program would total $8.3 billion, and would place a severe strain on both the protective scheme and the healthy pension plans which contribute to it. However, if only those plans actually expected to terminate in the next decade went bankrupt, the net liability which PBGC would be obliged to cover would total only $560 million, and would not pose as severe a threat.

The Corporation found:

> Two characteristics of multiemployer plans—pension portability and protection of an employee's benefits, even though the employee's employer leaves the plan—provide participants with much greater benefit security than single-employer plans. These features, however, have resulted in some benefit plans having very high unfunded liabilities for benefits of participants whose employers have ceased contributing.[85]

While the PBGC made no specific recommendations for resolving these difficulties, it did advance a number of alternative statutory proposals which could provide relief. These include changes in how the plans are organized, financed, and regulated, as well as revisions in the operation of the protective insurance program. The Congress is expected to act on these suggestions prior to July 1979.

IRA'S: CHANGES AND WARNINGS

ERISA, besides establishing protections and standards for pension plans, also provides a simple method of accruing retirement income for the approximately 35 million Americans who are not covered by a plan—the Individual Retirement Account (IRA). These employees are permitted to contribute 15 percent of earnings, up to $1,500 annually, tax free to a savings account, annuity, or mutual fund. The money can be utilized without tax penalties after the worker reaches the age of 59½. In 1976, the most recent year for which figures are available, nearly 2 million Americans deposited almost $2 billion into IRA's.

---

[82] Multiemployer plans exist primarily in the trucking, construction, retail, printing, shipping, and mining industries, where groups of employers pay into a single pension plan.

[83] For further background, see "Developments in Aging: 1977," pt. 1, p. 212.

[84] "Multiemployer Plan Required by Public Law 95-214," Pension Benefit Guaranty Corporation, July 1, 1978.

[85] Ibid., p. 3.

The 1978 Revenue Act [86] provides taxpayers with more time to place contributions in their IRA's. That decision can now be deferred until the date a tax return is filed—up to April 15—compared to the former deadline of February 14. This revision should reduce the number of instances in which taxpayers are charged a penalty for excess contributions. Further, this law permits a one-time, retroactive balancing out, on 1978 returns, for overpayments made in 1976 and 1977.

While the availability of IRA's has provided millions of uncovered employees with a new means of providing for their retirement, the Federal Trade Commission has issued warnings about certain plans issued by insurance companies which require fixed monthly payments. In a report to the House Ways and Means Committee, the FTC found that "the potential for consumer injury is substantial," and that thousands of persons have already lost the money which they invested in such plans.[87] The FTC report made a number of recommendations for improving the protection of persons seeking to establish IRA's, which are currently under consideration by the Internal Revenue Service and the Congress.

B. COURT ACTIONS AFFECTING PENSIONS

A major Supreme Court ruling on pension treatment of the sexes, and that forum's agreement to hear a controversial pension fraud case which has pitted Federal agencies against each other, promise to have major effects on the Nation's retirement income system.

EQUAL PENSIONS FOR WOMEN

Discriminatory treatment of employees is prohibited by title VII of the Civil Rights Act of 1964. In April 1978, the Supreme Court ruled, in a 6–2 decision,[88] that a pension plan operated by the city of Los Angeles which charged women 15 percent more than men for equal monthly retirement benefits violated that statute. Los Angeles had argued that this treatment should not be held illegal because women, as a class, do tend to live longer than men. However, the Court stressed that the civil rights statute protects individuals, and that most men and women (about 85 percent) die at similar ages:

> Even a true generalization about the class is an insufficient reason for disqualifying an individual to whom the generalization does not apply. . . . When insurance risks are grouped, the better risks always subsidize the poorer risks. . . . Nothing more than custom makes one "subsidy" seem less fair than the other.

Differential pension treatment occurs mainly in plans covering public rather than private employees. It is these plans which are expected to be primarily affected by the Court's decision.[89] The differences generally occur in the monthly contribution, the monthly retirement benefit, or the cost of options.

---

[86] Public Law 95–600, Nov. 6, 1978.
[87] The Wall Street Journal, May 5, 1978, p. 36.
[88] *City of Los Angeles, Department of Water and Power* v. *Manhart*, 98 S. Ct. 51, Apr. 25.
[89] New York Times, Apr. 27, 1978, p. 44.

However, the Court emphasized that insurance companies would remain free to weigh the relative longevity of men and women—and their presence in an employer's work force—in calculating retirement plan costs. Further, recognizing that the ruling was "a marked departure from past practice," the Court refused to award retroactive financial relief to the women who brought the suit. That denial of monetary damages stemmed largely from the Court's fear that such relief could threaten the solvency of many pension plans.

The Labor Department, responding to the Court's action, is preparing new policies to insure that employers do not discriminate against women in their pension plans and other employee benefit programs.[90]

PENSION FRAUD SLATED FOR REVIEW

John Daniels of Chicago worked for employers who, for 23 years, contributed to the Teamsters Pension Trust Fund on his behalf. But, in 1973 when he was forced to retire, Daniels was told that he would not receive a single penny from his pension because, 12 years before, he had been laid off for a 3-month period. Because ERISA's protections do not extend retroactively before its enactment, Daniels sued in Federal court on the grounds that his pension was a security, and that the lack of disclosure of his poor chance of ever collecting on it constituted a securities fraud under Federal law. In 1977, the U.S. Court of Appeals for the Seventh District agreed with Daniels. In February 1978, the Supreme Court accepted that case on appeal.

The Departments of Justice and Labor filed briefs with the Court urging that the lower decision be overturned because, they contended:

—There is no legislative or judicial record indicating that the securities laws were ever intended to apply to retirement plans.

—Affirming the decision would add a new layer of Federal law to pensions, beyond what exists now in collective bargaining legislation and ERISA.

—Retroactive application of securities law could result in suits being filed seeking billions in back payments, threatening the viability of the private pension system.[91]

The Securities and Exchange Commission, however, backed Daniels' claim and filed a brief, with the Court arguing that failure to affirm would open up new avenues to unscrupulous promoters seeking to profit from a limitation of antifraud provisions, and that projections of potential retroactive liabilities have been inaccurate and exaggerated.[92]

S. 3017, which would have negated the *Daniels* case by exempting pension interests from securities law, was not passed in the 95th Congress. It is likely that any pension revisions in the next Congress will strengthen ERISA's antifraud provisions, but such action will probably occur after the Supreme Court decision. The Supreme Court held in the *Daniels* case that an interest in a private pension was not subject to the antifraud provisions of the security laws.

---

[90] Pension World, Oct. 1978, p. 31.
[91] New York Times, Aug. 7, 1978, p. D1; Washington Post, Aug. 17, 1978, p. D15.
[92] Wall Street Journal, Aug. 21, 1978, p. 10; Pension World, October 1978, p. 34.

C. New Looks at the Pension System

ERISA exempted governmental retirement systems from its provisions but mandated that the Congress undertake studies to analyze the adequacy of funding, protections, and fiduciary standards for public plans; and make recommendations for Federal legislation to correct deficiencies.

In March 1978, the House Pension Task Force released the results of its 3-year examination of public pension systems. That report [93] found:

—A lack of understanding of the public employee retirement system (PERS) by officials and the public has resulted in an inadequate regulatory framework which fails to protect vital national interests.

—The absence of a single Federal agency to coordinate the administration and enforcement of the various laws relating to retirement income has precluded the development of a unified national policy with regard to public or private pensions. Inconsistency and confusion sharply limit the protections currently afforded public employees.

—The States have generally failed to establish clear standards or effective remedies for State and local government retirement systems. Court rulings have frequently reduced statutory protections.

—The absence of uniform accounting, auditing, and actuarial standards has resulted in serious deficiencies, inadequate information, and great potential for abuse.

—Benefit levels and provisions of public plans compare favorably with the private sector. However, a majority of the plans fail to meet ERISA's minimum vesting requirements.

—There is a compelling need for uniform actuarial measures, terminology, and standards to enable participants, officials, and taxpayers to assess the present and future funding needs of public retirement systems.

—Control over plan administration and management of assets is frequently inadequate. A lack of safeguards has resulted in many instances of fiduciary abuse. Further, the investment of public pension funds in securities issued by State and local government was found to be generally inappropriate. Uniform standards of fiduciary conduct are required.

These findings will be considered by the Congress as steps are taken to bring public employee plans under ERISA-like standards. That task will also be aided by the findings of the President's Commission on Pension Policy, established [94] to conduct a 1-year study of public and private plans. The Commission is required to report to the President its recommendations for policies "designed to insure that the Nation has effective and equitable retirement, survivor, and disability programs which take into account available resources and demographic changes that are expected into the middle of the next century."

---

[93] "Pension Task Force Report on Public Employee Retirement Systems," House Committee on Education and Labor, Mar. 15, 1978.

[94] Executive Order 12071, July 12, 1978.

X. TAXES AND THE ELDERLY

Tax policy occupied center stage for much of the 95th Congress, especially during 1978. Growing pressure to reduce Federal income taxes was fueled to a large degree by:

—Inflation, which often acts as a surtax for taxpayers who are pushed into higher tax brackets when they receive wage increases to compensate for price hikes.

—Social security tax increases to take effect in 1979, particularly for workers earning more than $20,000.

In the closing hours of the 95th Congress, the House and Senate concluded action on a $19 billion tax cut for individuals and businesses for fiscal year 1979. President Carter signed the 1978 Revenue Act into law on November 6, 1978.[95]

Additionally, the Congress voted to provide tax incentives for persons who install insulation and other energy conserving devices in their homes.[96] Congress also took steps to improve tax preparations assistance for older and younger Americans.[97]

A. Revenue Act of 1978

Individual income tax reductions totaling $13.6 billion for calendar year 1979 were included in the 1978 Revenue Act. Several of these provisions will have either a direct impact or a potentially important effect for older Americans. Some became effective in 1978, but most will become effective in 1979. Among the key provisions affecting older Americans:

INDIVIDUAL INCOME TAX REDUCTIONS

Public Law 95–600 reduces individual income taxes primarily through two devices for taxable year 1979. First, the tax brackets are widened. Thus, an individual will not move as quickly into higher tax brackets as under prior law. Second, the new law provides rate reductions in certain brackets.

INCREASE IN ZERO BRACKET AMOUNT

The zero bracket amount—commonly called the standard deduction—will increase from $2,200 to $2,300 for single persons and from $3,200 to $3,400 for married couples, beginning in 1979. This measure will benefit taxpayers who do not itemize their allowable deductions (e.g., medical, interest, taxes, and charitable contributions).

PERSONAL EXEMPTIONS

Public Law 95–600 increases the personal exemption deduction from $750 to $1,000 for each taxpayer, effective in 1979. Persons 65 or older will receive a double benefit from this provision, since they are entitled to an additional personal exemption because of age. However, the general tax credit—equal to $35 for each personal exemption or 2 percent of the first $9,000 of taxable income (above the zero bracket amount), with a minimum credit up to $180—terminates at the end of 1978. The increase in the personal exemption deduction, though, will equal or exceed the loss in tax benefits because of the repeal of the general tax credit.

---

[95] Public Law 95–600, approved Nov. 6, 1978.
[96] Public Law 95–618, approved Nov. 9, 1978.
[97] See page 197 for more details.

CAPITAL GAINS EXCLUSION FOR INDIVIDUALS

Beginning with sales after October 31, 1978, the capital gains exclusion for individuals is increased from 50 to 60 percent. The effect is that persons will be taxed on only 40 percent of their net capital gains, compared with 50 percent under prior law. Capital gains typically occur on the sale of stocks, bonds, or other capital assets.

EXCLUSION OF GAIN ON RESIDENTIAL SALES

One of the most significant measures for older Americans is a modified version of the Church-Packwood-Nelson amendment[98] to permit taxpayers 55 years or older to exclude up to $100,000 of gain from the sale of a principal residence from Federal income tax. A taxpayer can claim this exclusion only once. Qualifying persons who sell their homes on or after July 27, 1978, will be eligible for the exclusion.

Under prior law, homeowners 65 years or older could exclude the entire gain on the sale of a personal residence, provided (1) the adjusted sales price did not exceed $35,000, and (2) they owned and used the home as a principal residence for 5 years within the 8-year period preceding the sale. If the adjusted sales price exceeded $35,000, the amount excludable from Federal income tax was the total gain multiplied by $35,000 divided by the adjusted sales price of the personal residence.

The new law changes the ownership and use tests for older homeowners to qualify for the exclusion. They must own and use the home as a principal residence for 3 years within the 5-year period preceding the sale. A special transition rule applies to persons 65 or older who sell their homes before July 26, 1981. They may qualify under the former ownership and use test (5 out of 8 years preceding the sale) or the new rule (3 out of 5 years preceding the sale). In addition, taxpayers 65 or older who claimed an exclusion on the sale of a home before July 27, 1978, may also exclude the gain on the sale of another home on or after July 27, 1978.

The Church-Packwood-Nelson amendment makes no change in the so-called rollover provision, which permits individuals of all ages to postpone the tax on the gain from the sale of a home if they purchase a replacement residence costing as much or more than the one sold.

Four examples are provided to illustrate the time savings of the amendment when a husband and wife (one or both of whom are 55 or older) sell their personal residences and do not purchase a replacement residence costing as much or more than their present residence. The following tax computations assume that the taxpayers claim the standard deduction and do not income average.

---

[98] Other sponsors of the Church-Packwood-Nelson amendment include Senators McIntyre, Stafford, Stone, Randolph, Anderson, Goldwater, McGovern, Inouye, Wallop, Domenici, DeConcini, Riegle, Clark, Thurmond, Durkin, Melcher and Bayh.

Situation A.—Family income is $25,000, and the home was purchased in 1968 for $27,000. It has just been sold for $54,000, showing a capital gain of $27,000. With a capital gains tax in effect on this profit, the family's total bill would equal $9,751 (including a $525 minimum tax and $4,288 in incomes taxes). Total savings because of the amendment: $5,463.

Situation B.—Family income is $20,000, and the home was purchased in 1968 for $27,000. It has just been sold for $54,000, showing a capital gain of $27,000. With a capital gains tax in effect on this profit, the family's total tax bill would equal $7,747 (including a $525 minimum tax and $2,899 in income taxes). Total savings because of the amendment: $4,848.

Situation C.—Family income is $15,000, and the home was purchased in 1968 for $20,000. It has just been sold for $40,000, showing a capital gain of $20,000. With a capital gains tax in effect on this profit, the family's total tax bill would equal $4,288 (including no minimum tax, but $1,701 in income taxes). Total savings because of the amendment: $2,587.

Situation D.—Family income is $10,000, and the home was purchased in 1958 for $10,000. It has just been sold for $30,000, showing a capital gain of $20,000. With a capital gains tax in effect on this profit, the family's total tax bill would equal $2,899 (including no minimum tax, but $757 in income taxes). Total savings because of the amendment: $2,142.[99]

CHILD CARE SERVICES PROVIDED BY GRANDPARENTS

Qualifying taxpayers may claim a 20-percent credit on up to $2,000 of child care expenses for one child ($4,000 for two or more children), for a maximum credit of $400 ($800 for two or more children). Under prior law, the credit applied if the child care was performed by nonrelatives or by aunts, uncles, nieces, or nephews, but not by grandparents. Beginning in 1979, the new tax law provides that payments to grandparents will qualify for the child care tax credit.

---

[99] See following table:

EFFECT OF AMENDMENT

	Situation A	Situation B	Situation C	Situation D
Income	$25,000	$20,000	$15,000	$10,000
Tax before capital gain [1]	4,288	2,899	1,701	757
Selling price of home (July 27, 1978 or later)	54,000	54,000	40,000	30,000
Cost	27,000	27,000	20,000	10,000
Gain	27,000	27,000	20,000	20,000
Tax with capital gain [2]	9,226	7,222	4,288	2,899
Minimum tax [3]	525	525	0	0
Total tax [4]	9,751	7,747	4,288	2,899
Tax before capital gain and minimum tax	4,288	2,899	1,701	757
Savings under the amendment	5,463	4,848	2,587	2,142

[1] The tax computation assumes that the taxpayers claim the standard deduction.

[2] Before Nov. 1, 1978, taxpayers reported 50 percent of their long-term capital gains. Effective Nov. 1, 1978, taxpayers report only 40 percent of their long-term capital gains.

[3] Before Nov. 1, 1978, the minimum tax was computed by taking the total of tax preferences (e.g., untaxed long-term capital gains) in excess of $10,000, and then multiplying the net amount by 15 percent. Gains from the sale of personal residences on or after Nov. 1, 1978, are not subject to the minimum tax.

[4] The computation does not include income averaging, which would reduce the tax.

B. TAX COUNSELING ASSISTANCE

Congress enacted two measures to make tax counseling assistance more readily available for younger and older Americans. First, the fiscal 1979 Treasury-Postal Services Appropriations Act[100] includes an amendment sponsored by Senators Chiles and Church to increase funding from $800,000 to $1,300,000 for the volunteer income tax assistance (VITA) program. VITA is administered by the Internal Revenue Service, which trains tax consultants to assist taxpayers in preparing their returns.

IRS plans to use the additional funding to make tax counseling assistance more readily available for taxpayers encountering difficulty with Federal income tax forms. In addition, the amendment will enable IRS to improve and strengthen the quality review and program management of VITA. IRS also plans to update its training program to assure that tax counselors are completely current in their understanding of the tax law.

Second, the 1978 Revenue Act builds upon the VITA program by establishing an older Americans tax counseling assistance program for taxpayers 60 or older. This measure authorizes IRS to enter into training and technical assistance agreements with private or public nonprofit agencies or organizations to prepare volunteers to provide tax counseling assistance for elderly individuals. The legislation would permit IRS to reimburse volunteers for out-of-pocket expenses incurred by them in counseling taxpayers or undergoing training. IRS is also authorized to conduct special alerts to make older Americans aware of helpful tax relief provisions, such as the tax credit for the elderly or the exclusion on the sale of a personal residence.

C. TAX CREDIT FOR THE ELDERLY

The tax credit for the elderly is designed primarily for persons with little or no social security benefits, including policemen, firemen, teachers, and other Government pensioners. Taxpayers 65 or older may claim a 15-percent credit on up to $2,500 for individuals and $3,750 for elderly couples. This produces a maximum savings of $375 for a single person ($2,500 × .15 = $375) and $562.50 ($3,750 × .15 = $562.50) for a couple.

The maximum amounts for computing the credit, however, are reduced (1) dollar-for-dollar by social security and other tax-exempt Federal benefits, and (2) by $1 for each $2 of adjusted gross income above $7,500 for aged individuals and $10,000 for elderly couples. Thus, the credit is phased out completely for single persons with income of $12,500 or more and aged couples with $17,500 or more.

As approved by the Senate on October 10, the 1978 Revenue Act (H.R. 13511) would have increased the maximum tax credit from $375 to $450 for an elderly individual and from $562.50 to $675 for an aged couple. The Senate-passed bill would also have raised the adjusted gross income phase-out provision from $7,500 to $15,000 for qualifying single persons and from $10,000 to $17,500 for eligible couples. This change would have permitted individuals with up to $21,000 in adjusted gross income and couples with up to $26,500 in income to be potentially eligible for the 15-percent credit. The House approved an identical proposal (H.R. 9893) on October 10.

---

[100] Public Law 95-429, approved Oct. 10, 1978.

However, the conferees deleted the elderly tax credit provision from the final version of the 1978 Revenue Act.

D. THE ENERGY TAX ACT OF 1978

The 1978 Energy Tax Act [101] includes several provisions to encourage energy conservation. Of special importance for homeowners, the act provides a 15-percent credit on up to $2,000 in expenditures for the installation of insulation and other energy-conserving items. Persons with $2,000 or more in qualifying expenditures can claim the maximum $300 credit. Items eligible for the credit include: (1) insulation, (2) furnace replacement burner, (3) automatic flue opening modifier, (4) automatic furnace ignition system, (5) exterior storm or thermal door or window, (6) automatic setback thermostat, (7) electric energy usage display meter, and (8) exterior caulking or weatherstripping. The credit is available for expenditures dating back to April 20, 1977. However, taxpayers are to claim all 1977 and 1978 credits on their 1978 tax returns.

XI. WHITE HOUSE CONFERENCE IN 1981

Congress acted in 1978 to assure that White House Conferences on Aging will continue their one-a-decade pattern.[102]

Health, Education, and Welfare Secretary Joseph Califano and Administration on Aging Commissioner Robert Benedict endorsed congressional [103] proposals for the conference at hearings in the Senate and the House of Representatives.

As requested by key members of this committee,[104] the final legislation [105] put heavy emphasis on developing a factual base at an early date. It stated:

> . . . the Secretary shall assure that current and adequate statistical data and other information on the well-being of

---

[101] Public Law 95-618, approved Nov. 9, 1978.

[102] Authority for the conference was included in Public Law 95-478, signed Oct. 10, 1978.

[103] Congressionally mandated White House Conferences on Aging took place in 1971 and 1961. A National Conference on Aging in 1950 was convened at the suggestion of Oscar Ewing, head of the Federal Security Agency. Henry Pratt, in his book "The Gray Lobby," described the 1950 predecessor to the later White House conferences: ". . . the 816 delegates in attendance did give explicit attention to the problems of aging persons and helped to legitimize this topic as a focus of public concern—something that had not been done before." The official report of the 1961 White House Conference, "The Nation and Its Older People," said: "From Jan. 9 to 12, 1961, more than 2,500 delegates met in Washington and participated in this forum. Behind them lay nearly 2 years of preconference study and analysis by thousands of professional and lay persons in the States and communities. The delegates represented 53 States and territories, and more than 300 national voluntary organizations interested or active in the field of aging." The 1971 conference report, "Toward a National Policy on Aging," said that 4,000 delegates met "to explore the circumstances of the Nation's older population and to recommend policies needed to improve those circumstances."

[104] Secretary Califano, in testimony before the House Subcommittee on Select Education, said on Mar. 20: "We feel that this conference will provide a similar forum to that in 1971: a forum for developing comprehensive approaches to the problems that will confront the Nation's elderly citizens over the next generation." Commissioner on Aging Benedict, before the Senate Subcommittee on Aging on Apr. 21, said he was pleased that the bill under consideration contained authority for a White House Conference on Aging: "The demographic trends which I set forth earlier give special emphasis to the need for such a conference in order to stimulate public attention to the 'graying of America,' and to generate an effective response to the issues raised by the 'graying' process."

[105] Senator Frank Church, then chairman of the committee, and Ranking Minority Member Pete Domenici, in the preface to "Developments in Aging: 1977," report of the Senate Committee on Aging, stated: "As valuable as the 1971 conference was, the 1981 conference can accomplish far more if: . . . determined efforts are made to obtain essential data well in advance of the actual conference . . . preparations for the conference are begun at the grassroots level at the earliest possible date . . . wherever possible, pilot programs to demonstrate experimental approaches are in place for close examination before and during the conference." For additional information about the legislative origins of the 1981 conference, see pp. 247-249, "Developments in Aging: 1977."

> older individuals in the United States are readily available, in advance of the conference, together with such information as may be necessary to evaluate Federal programs and policies related to aging.

In its declaration of need for the 1981 White House Conference, the law said:

> The Congress finds that:
>
> (1) the number of individuals fifty-five years of age or older was approximately 43,000,000 in 1976, and will, by the end of this century, be over 57,000,000;
>
> (2) nearly 5,200,000 individuals fifty-five years of age or older had incomes below the poverty level in 1976, as determined by the Federal Government;
>
> (3) there is a great need to improve the economic well-being of older individuals;
>
> (4) there is a great need to make comprehensive and quality health care more readily available to older individuals;
>
> (5) there is a great need for expanding the availability of suitable and reasonably priced housing for older individuals, together with services needed for independent or semi-independent living;
>
> (6) there is a great need for a more comprehensive and effective social service delivery system for older individuals;
>
> (7) there is a great need for a more comprehensive long-term care policy responsive to the needs of older patients and their families;
>
> (8) there is a great need to promote greater employment opportunities for middle-aged and older individuals who want or need to work;
>
> (9) there is a great need to develop a national retirement policy that contributes to the fulfillment, dignity, and satisfaction of retirement years for older individuals;
>
> (10) there is a great need for a national policy with respect to increasing, coordinating, and expediting biomedical and other appropriate research directed at determining the causes of the aging process; and
>
> (11) false stereotypes about aging and the process of aging are prevalent throughout the Nation and policies should be developed to overcome such stereotypes.
>
> (b)(1) It is the policy of the Congress and the Federal Government should work jointly with the States and their citizens to develop recommendations and plans for action to meet the challenges and needs of older individuals, consistent with the objectives of this title.
>
> (2) In developing programs for the aging pursuant to this title, emphasis should be placed upon the right and obligation of older individuals to free choice and self-help in planning their own futures.

Other features of the final legislation include:

—The conference will be planned and conducted under the direction of the HEW Secretary, together with the Commissioner of Aging, the Director of the National Institute on Aging, "and the heads of such other Federal departments and agencies as are appropriate. . . ."

—Participants will include "representatives of the Federal, State, and local governments, professional and lay people who are working in the field of aging (including researchers on problems of the elderly and the process of aging) and representatives of the general public, including older individuals."

—The final conference report—including "a statement of a comprehensive coherent national policy on aging together with recommendations for the implementation of the policy" will be submitted to the President no later than 180 days after conference adjournment. Within 90 days after this, the Secretary of HEW is to transmit to the President and to the Congress departmental recommendations for administration action and legislation to implement the recommendations.

—A conference advisory committee will include representation from the Federal Council on Aging, other appropriate public agencies, and private nonprofit organizations. The Secretary also has the authority to establish "such other committees, including technical committees as may be necessary to assist in planning, conducting, and reviewing the conference." Each such committee must include "individuals from low-income families and from minority groups. A majority of the public members of each such committee shall be 55 years of age or older."

Conference planning is in preliminary stages. The President's supplemental budget request for fiscal year 1979 allocates $3 million for the conference.

XII. UNITED STATES, U.N. ACTION ON A WORLD ASSEMBLY IN 1982

Acting on a resolution [106] advanced by the U.S. delegation, the General Assembly of the United Nations, late in 1978, authorized a World Assembly on Aging in 1982.

The resolution, as approved by the third Committee on the U.N. on November 16 and by the fifth committee on December 18:

—Authorizes the Assembly "as a forum to launch an international action programme aimed at guaranteeing economic and social security to older persons, as well as opportunities to contribute to national development." [107]

—Postpones until a later date a decision on the feasibility of an International Year of the Elderly.

—Requests the Secretary-General to submit a draft program for the World Assembly, with recommendations on its organization and objectives.

Dr. Ruth Schachter Morgenthau, U.S. Representative to the U.N. Commission for Social Development, said in a statement of support on October 30 that older persons of all nations "are long overdue for priority consideration in the United Nations."

---

[106] For additional information about the resolution and prior actions by the U.S. Congress, see pp. 245–7 of "Developments in Aging: 1977," report of the U.S. Senate Special Committee on Aging.

[107] From text of A/C. 3/33/L. 21/Rev. 1, agenda item 87, 33d session, third committee "Problems of the Elderly and the Aged." United Nations, Nov. 14, 1978.

She added:

> Modern science and improved medical technology have assured greater longevity. As a result, all nations are experiencing an increase in numbers of older citizens. For example, in 1970, there was a worldwide population of approximately 291 million persons 60 years and over. It is projected that this will increase to nearly 585 million over the next 22 years. Significantly, these increases will be more pronounced in the developing nations, where the over-60 population is expected to increase by 158 percent, while the total population is expected to increase by 98 percent. By the year 2000, 354 million older persons will inhabit the developing nations.

The U.N. Secretary General, in a report [108] listing 44 member states which supported the World Assembly and 14 which opposed it, also emphasized the need for more international attention:

> In countries where the situation of the aging was not yet severe, it was emphasized that preventive action should be initiated immediately.

U.S. FUNDING ACTION

The 1978 International Development and Food Assistance Act (signed into law on October 6 as Public Law 95–424) includes an amendment, advanced in the Senate by Frank Church and in the House by Claude Pepper, authorizing the United States to contribute up to 25 percent of the cost of a World Assembly on Aging or $1 million, whichever is lower. Action on the actual appropriation is to be sought in 1979.

---

[108] "Problems of the Elderly and the Aged," report of the Secretary-General, United Nations General Assembly, Sept. 26, 1978.

ADDITIONAL VIEWS OF SENATOR HEINZ

In chapter V, "New Directions in Nursing Home Care," the report states that the two long-term care issues focused on in 1978 were the high cost of care and quality of care. Although I did not serve on the Aging Committee in the 95th Congress, my concern with the quality of care provided in nursing homes prompted a Senate Governmental Affairs Federal Spending Practices and Open Government Subcommittee investigation of those Federal programs established to insure this care.

The hearings held by the subcommittee revealed surprising consensus that the elaborate and costly system of standards, survey, and enforcement DHEW established to insure the quality of care in nursing homes was a failure. The standards concentrated on the facility and its assumed capabilities, but ignored the actual medical, psychological, and social care delivered to the patient. The survey/certification process was uneven, repetitive, and often failed to identify deficiencies in the homes. Even when substandard homes were identified, the available enforcement mechanisms for bringing nursing homes into compliance were woefully inadequate.

A copy of the hearings and a planned subcommittee report provide added background for any review and comment of the proposed regulations for SNF's and ICF's, due to be announced by HCFA in late spring. I am sure the Aging Committee will want to follow up on their oversight responsibilities when the proposed regulations are issued.

John Heinz.

Supplement 1

HEARINGS HELD BY THE SPECIAL COMMITTEE ON AGING DURING 1978 AND JANUARY-MARCH 1979

Tax Forms and Tax Equity for Older Americans:
  Washington, D.C., February 24, 1978.
Health Care for Older Americans: The "Alternatives" Issue:
  Part 8, Washington, D.C., April 17, 1978.
Medi-Gap: Private Health Insurance Supplements to Medicare:
  Part 1, Washington, D.C., May 16, 1978.
  Part 2, Washington, D.C., June 29, 1978.
Retirement, Work, and Lifelong Learning:
  Part 1, Washington, D.C., July 17, 1978.
  Part 2, Washington, D.C., July 18, 1978.
  Part 3, Washington, D.C., July 19, 1978.
  Part 4 ,Washington, D.C., September 8, 1978.
Medicaid Anti-Fraud Programs: The Role of State Fraud Control Units:
  Washington, D.C., July 25, 1978.
Vision Impairment Among Older Americans:
  Washington, D.C., August 3, 1978.
The Federal-State Effort in Long-Term Care for Older Americans: Nursing Homes and "Alternatives":
  Chicago, Ill., August 30, 1978.
Condominiums and the Older Purchaser:
  Part 1, Hallandale, Fla., November 28, 1978.
  Part 2, West Palm Beach, Fla., November 29, 1978.
Older Americans in the Nation's Neighborhoods:
  Part 1, Washington, D.C., December 1, 1978.
  Part 2, Oakland, Calif., December 4, 1978.
The Impact of Rising Energy Costs on Older Americans:
  Part 7, Missoula, Mont., February 14, 1979.
Commodities and Nutrition Program for the Elderly:
  Missoula, Mont., February 14, 1979.

Supplement 2

PUBLICATIONS LIST

COMMITTEE HEARINGS AND REPORTS

No asterisk indicates single copy available from committee supply. Address requests to: Publications, Special Committee on Aging, Room G-233, Dirksen Building, Washington, D.C. 20510. Multiple copies may be purchased from Superintendent of Documents, Government Printing Office, Washington, D.C. 20402.

One asterisk indicates committee's supply exhausted.

Two asterisks indicate all supplies exhausted. Libraries designated as "Depository Libraries" receive printed or microform copies of all Government publications for inter-library loan and reference service.

Three asterisks indicate Government Printing Office supply exhausted; single copy available from committee supply.

With a request for printed copies of documents, please enclose self-addressed label.

REPORTS

Action for the Aged and Aging, Report No. 128, March 1961.**
Action for the Aged and Aging, summary and recommendations of Report No. 128, 1961.**
Developments in Aging, 1959–63, Report No. 8, February 1963.**
Developments in Aging, 1963–64, Report No. 124, March 1965.**
Developments in Aging, 1965, Report No. 1073, March 15, 1966.**
Developments in Aging, 1966, Report No. 169, April 1967.***
Developments in Aging, 1967, Report No. 1098, April 1968.**
Developments in Aging, 1968, Report No. 91–119, April 1969.**
Developments in Aging, 1969, Report No. 91–875, February 1970.**
Developments in Aging, 1970, Report No. 92–46, March 1971.**
Developments in Aging: 1971 and January–March 1972, Report No. 92–784, April 1972.**
Developments in Aging: 1972 and January–March 1973, Report No. 93–147, May 1973.**
Developments in Aging: 1973 and January–March 1974, Report No. 93–846, May 1974.**
Developments in Aging: 1974 and January–April 1975, Report No. 94–250, June 1975 (Cat. No. 94/1: S. Rept. 250)—$3.60.*
Developments in Aging: 1975 and January–May 1976—Part 1, Report No. 94–998, June 1976 (Cat. No. 94/2: S. Rept. 998/Pt. 1)—$2.95.*

Developments in Aging: 1975 and January–May 1976—Part 2, Report No. 94–998, June 1976 (Cat. No. 94/2: S. Rept. 998/Pt. 2)—$2.55.*

Developments in Aging: 1976—Part 1, Report No. 95–88, March 1977 (Cat. No. 95/1: S. Rept. 88/Pt. 1)—$3.25.

Developments in Aging: 1976—Part 2, Report No. 95–88, March 1977 (Cat. No. 95/1: S. Rept. 88/Pt. 2)—$3.25.

Developments in Aging: 1977—Part 1, Report No. 95–771, April 1978 (Cat. No. 95/2: S. Rept. 771/Pt. 1)—$4.25.

Developments in Aging: 1977—Part 2, Report No. 95–771, April 1978 (Cat. No. 95/2: S. Rept. 771/Pt. 2)—$3.75.

Developments in Aging: 1978—Part 1, Report No. 96——, March 1979 (Cat. No. 96/1: S. Rept. —/Pt. 1)-$-.—.

Developments in Aging: 1978—Part 2, Report No. 96——, March 1979 (Cat. No. 96/1: S. Rept. —/Pt. 2)—$-.—.

Comparison of Health Insurance Proposals for Older Persons, 1961, committee print, April 3, 1961.**

The 1961 White House Conference on Aging, basic policy statements and recommendations, committee print, May 15, 1961.**

New Population Facts on Older Americans, 1960, staff report, committee print, May 24, 1961.**

Basic Facts on the Health and Economic Status of Older Americans, staff report, committee print, June 2, 1961.**

Health and Economic Conditions of the American Aged, chart book, committee print, June 1961.**

State Action To Implement Medical Programs for the Aged, staff report, committee print, June 8, 1961.**

A Constant Purchasing Power Bond: A Proposal for Protecting Retirement Income, committee print, August 1961.**

Mental Illness Among Older Americans, committee print, September 8, 1961.**

Comparison of Health Insurance Proposals for Older Persons, 1961–62, committee print, May 10, 1962.**

Background Facts on the Financing of the Health Care of the Aged, committee print, excerpts from the report of the Division of Program Research, Social Security Administration, Department of Health, Education, and Welfare, May 24, 1962.**

Statistics on Older People: Some Current Facts About the Nation's Older People, June 14, 1962.**

Performance of the States: 18 Months of Experience With the Medical Assistance for the Aged (Kerr-Mills) Program, committee print report, June 15, 1962.**

Housing for the Elderly, committee print report, August 31, 1962.**

Some Current Facts About the Nation's Older People, October 2, 1962.**

A Compilation of Materials Relevant to the Message of the President of the United States on Our Nation's Senior Citizens, committee print, June 1963.**

Medical Assistance for the Aged: The Kerr-Mills Program, 1960–63, committee print report, October 1963.**

Blue Cross and Private Health Insurance Coverage of Older Americans, committee print report, July 1964.**

Increasing Employment Opportunities for the Elderly—Recommendations and Comment, committee print report, August 1964.**

Services for Senior Citizens—Recommendations and Comment, Report No. 1542, September 1964.**

Major Federal Legislative and Executive Action Affecting Senior Citizens, 1963–64, staff report, committee print, October 1964.**

Frauds and Deceptions Affecting the Elderly—Investigations, Findings, and Recommendations, 1964, committee print report, January 1965.**

Extending Private Pension Coverage, committee print report, June 1965.**

Health Insurance and Related Provisions of Public Law 89–97: The Social Security Amendments of 1965, committee print, October 1965.**

Major Federal Legislative and Executive Actions Affecting Senior Citizens, 1965, staff report, committee print, November 1965.**

The War on Poverty As It Affects the Elderly, Report No. 1287, June 1966.**

Services to the Elderly on Public Assistance, committee print report, March 1966.**

Needs for Services Revealed by Operation Medicare Alert, committee print report, October 1966.**

Tax Consequences of Contributions to Needy Older Relatives, Report No. 1721, October 13, 1966.**

Detection and Prevention of Chronic Disease Utilizing Multiphasic Health Screening Techniques, committee print report, December 30, 1966.**

Reduction of Retirement Benefits Due to Social Security Increases, committee print report, August 21, 1967.**

Economics of Aging: Toward a Full Share in Abundance, working paper, committee print, March 1969.** [1]

Homeownership Aspects of the Economics of Aging, working paper, factsheet, July 1969.** [1]

Health Aspects of the Economics of Aging, working paper, committee print, July 1969 (revised).** [1]

Social Security for the Aged: International Perspectives, working paper, committee print, August 1969.** [1]

Employment Aspects of the Economics of Aging, working paper, committee print, December 1969.** [1]

Pension Aspects of the Economics of Aging: Present and Future Roles of Private Pensions, working paper, committee print, January 1970.** [1]

The Stake of Today's Workers in Retirement Security, working paper, committee print, April 1970.** [1]

Legal Problems Affecting Older Americans, working paper, committee print, August 1970.** [1]

Income Tax Overpayments by the Elderly, Report No. 91–1464, December 1970.**

Older Americans and Transportation: A Crisis in Mobility, Report No. 91–1520, December 1970.**

Economics of Aging: Toward a Full Share in Abundance, Report No. 91–1548, December 31, 1970.**

Medicare, Medicaid Cutbacks in California, working paper, factsheet, May 10, 1971.** [1]

---

[1] Working paper incorporated as an appendix to the hearing.

Mental Health Care and the Elderly: Shortcomings in Public Policy, Report No. 92–433, November 1971.**

The Multiple Hazards of Age and Race: The Situation of Aged Blacks in the United States, Report No. 92–450, November 1971.**

The Nation's Stake in the Employment of Middle-Aged and Older Persons, working paper, committee print, July 1971.**

The Administration on Aging—Or a Successor? committee print report, October 1971.**

Alternatives to Nursing Home Care: A Proposal, committee print, October 1971.**

Advisory Council on the Elderly American Indian, working paper, committee print, November 1971.**

Elderly Cubans in Exile, working paper, committee print, November 1971.**

A Pre-White House Conference on Aging: Summary of Developments and Data, Report No. 92–505, November 1971.**

Research and Training in Gerontology, working paper, committee print, November 1971 (Cat. No. Y4.Ag4:G31)—90¢.*

Making Services for the Elderly Work: Some Lessons From the British Experience, committee print report, November 1971.**

1971 White House Conference on Aging, a report to the delegates from the conference sections and special concerns sessions, December 1971.**

Home Health Services in the United States, committee print report, April 1972 (Cat. No. Y4.Ag4:H34/11)—$1.30.*

Proposals to Eliminate Legal Barriers Affecting Elderly Mexican-Americans, working paper, committee print, May 1972 (Cat. No. Y4.Ag4:M57/2)—25¢.*

Cancelled Careers: The Impact of Reduction-in-Force Policies on Middle-Aged Federal Employees, committee print report, May 1972 (Cat. No. Y4.Ag4:C18/2)—55¢.*

Action on Aging Legislation in 92d Congress, committee print, October 1972.**

Legislative History of the Older Americans Comprehensive Services Amendments of 1972, joint committee print, prepared by the Subcommittee on Aging of the Committee on Labor and Public Welfare and the Special Committee on Aging, December 1972.**

The Rise and Threatened Fall of Service Programs for the Elderly, report by the Subcommittee in Federal, State, and Community Services, Report No. 93–94, March 28, 1973.**

Housing for the Elderly: A Status Report, working paper, committee print, April 1973 (Cat. No. Y4.Ag4:H81/4)—35¢.*

Older Americans Comprehensive Services Amendments of 1973, committee print, June 1973 (Cat. No. Y4.Ag4:SE6/8)—$2.45.*

Home Health Services in the United States: A Working Paper on Current Status, committee print, July 1973.**

Economics of Aging: Toward a Full Share in Abundance, index to hearings and reports, committee print, July 1973.***

Research on Aging Act, 1973, Report No. 93–299, committee print, July 1973 (Cat. No. Y4.Ag4:R31/6)—35¢.

Post-White House Conference on Aging Reports, 1973 (joint committee print, prepared by the Subcommittee on Aging of the Committee on Labor and Public Walfare and the Special Committee on Aging, September 1973.**

Improving the Age Discrimination Law, working paper, committee print, September 1973.***

The Proposed Fiscal 1975 Budget: What It Means for Older Americans, committee print, February 1974 (Cat. No. Y4.Ag4:B85)—35¢.*

Protecting Older Americans Against Overpayment of Income Taxes: A Checklist of Itemized Deductions, committee print, February 1974.**

Developments and Trends in State Programs and Services for the Elderly, committee print report, November 1974 (Cat. No. Y4.Ag4:ST1)—$1.30.*

Private Health Insurance Supplementary to Medicare, working paper, committee print, December 1974 (Cat. No. Y4.Ag4:H34/15)—50¢.*

Nursing Home Care in the United States: Failure in Public Policy, reports by the Subcommittee on Long-Term Care:

- Introductory Report, Report No. 93-1420, November 1974 (Cat. No. 93/2, S. Rept. 1420)—$1.75.*
- Supporting Paper No. 1, "The Litany of Nursing Home Abuses and an Examination of the Roots of Controversy," committee print report, December 1974 (Cat. No. Y4.Ag4:N93/5/No. 1)—$1.20.*
- Supporting Paper No. 2, "Drugs in Nursing Homes: Misuse, High Costs, and Kickbacks," committee print report, January 1975 (Cat. No. Y4.Ag4:N93/5/No. 2)—$1.20.*
- Supporting Paper No. 3, "Doctors in Nursing Homes: The Shunned Responsibility," committee print report, February 1975 (Cat. No. Y4.Ag4:N93/5/No. 3)—95¢.*
- Supporting Paper No. 4, "Nurses in Nursing Homes: The Heavy Burden (the Reliance on Untrained and Unlicensed Personnel)," committee print report, March 1975 (Cat. No. Y4.Ag4:N93/5/No. 4)—$1.50.*
- Supporting Paper No. 5, "The Continuing Chronicle of Nursing Home Fires," committee print report, August 1975 (Cat. No. Y4.Ag4:N93/5/No. 5)—$2.10.*
- Supporting Paper No. 6, "What Can Be Done in Nursing Homes: Positive Aspects in Long-Term Care," committee print report, September 1975 (Cat. No. Y4.Ag4:N93/5/No. 6)—$1.70.*
- Supporting Paper No. 7, "The Role of Nursing Homes in Caring for Discharged Mental Patients (and the Birth of a For-Profit Boarding Home Industry)," committee print report, March 1976 (Cat. No. Y4.Ag4:N93/5/No. 7)—$1.60.*

Protecting Older Americans Against Overpayment of Income Taxes, committee print, January 1975.**

Future Directions in Social Security: An Interim Report, committee print, February 1975 (Cat. No. Y4.Ag4:SO1/3)—50¢.

Senior Opportunities and Services (Directory of Programs), committee print, February 1975 (Cat. No. Y4.Ag4:OP5)—$4.65.*

Action on Aging Legislation in 93d Congress, committee print, February 1975.***

The Proposed Fiscal 1976 Budget: What It Means for Older Americans, committee print, February 1975 (Cat. No. Y4.Ag4:B85/976)—30¢.*

Women and Social Security: Adapting to a New Era, working paper, committee print, October 1975 (Cat. No. Y4.Ag4:W84)—$1.10.

Congregate Housing for Older Adults, Report No. 94–478, November 1975 (Cat. No. 94/1, S. Rept. 478)—80¢.

Protecting Older Americans Against Overpayment of Income Taxes, committee print, January 1976.**

The Proposed Fiscal 1977 Budget: What It Means for Older Americans, committee print (Cat. No. Y4.Ag4:B85/977)—35¢.

Fraud and Abuse Among Clinical Laboratories, Report No. 94–944, June 15, 1976 (Cat. No. 94/2, S. Rept. 944)—$1.35.

Recession's Continuing Victim: The Older Worker, committee print, July 1976 (Cat. No. Y4.Ag4:R24/2)—45¢.

Adult Day Facilities for Treatment, Health Care, and Related Services, committee print, September 1976 (Cat. No. Y4.Ag4:T71)—$1.40.*

Termination of Social Security Coverage: The Impact on State and Local Government Employees, committee print, September 1976 (Cat. No. Y4.Ag4:SO1/4)—75¢.

Fraud and Abuse Among Practitioners Participating in the Medicaid Program, committee print, August 1976 (Cat. No. Y4.Ag4: M46/6)—$2.65.*

Witness Index and Research Reference, committee print, November 1976 (Cat. No. Y4.Ag4:W78/959–75)—$2.40.

Action on Aging Legislation in 94th Congress, committee print, November 1976 (Cat. No. Y4.Ag4:Ag4/6)—40¢.

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1976.**

The Proposed Fiscal 1978 Budget: What It Means for Older Americans, committee print, March 1977 (Cat. No. Y4.Ag4:B85/978)—35¢.

Protective Services for the Elderly, committee print, July 1977 (Cat. No. Y4.Ag4:Se6/10)—$2.20.

Kickbacks Among Medicaid Providers, Report No. 95–320, June 1977 (Cat. No. 95/1:S. Rept. 320)—$1.30.

The Next Steps in Combating Age Discrimination in Employment: With Special Reference to Mandatory Retirement Policy, committee print, August 1977 (Cat. No. Y4.Ag4:R31/7)—$1.20.

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1977 (Cat. No. Y4.Ag4:In2/4/977) —80¢.

The Proposed Fiscal 1979 Budget: What It Means for Older Americans, committee print, February 1978 (Cat. No. Y4.Ag4:B85/979)—80¢.

Paperwork and the Older Americans Act: Problems of Implementing Accountability, committee print, June 1978 (Cat. No. Y4.Ag4: P19)—$2.30.

Single Room Occupancy: A Need for National Concern, committee print, June 1978 (Cat. No. Y4.Ag4:Si6)—$1.90.

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1978 (Cat. No. Y4.Ag4:In2/4/978)—90¢.

Action on Aging Legislation in the 95th Congress, committee print, December 1978 (Cat. No. Y4.Ag4:L52/3/978)—$1.10.

The Proposed Fiscal 1980 Budget: What It Means for Older Americans, committee print, February 1979 (Cat. No. Y4.Ag4:B85/980—$1.10.

With a request for printed copies of documents, please enclose self-addressed label

HEARINGS

Retirement Income of the Aging:**
- Part 1. Washington, D.C., July 12-13, 1961.
- Part 2. St. Petersburg, Fla., November 6, 1961.
- Part 3. Port Charlotte, Fla., November 7, 1961.
- Part 4. Sarasota, Fla., November 8, 1961.
- Part 5. Springfield, Mass., November 29, 1961.
- Part 6. St. Joseph, Mo., December 11, 1961.
- Part 7. Hannibal, Mo., December 13, 1961.
- Part 8. Cape Girardeau, Mo., December 15, 1961.
- Part 9. Daytona Beach, Fla., February 14, 1962.
- Part 10. Fort Lauderdale, Fla., February 15, 1962.

Problems of the Aging (Federal-State activities):**
- Part 1. Washington, D.C., August 23-24, 1961.
- Part 2. Trenton, N.J., October 23, 1961.
- Part 3. Los Angeles, Calif., October 24, 1961.
- Part 4. Las Vegas, Nev., October 25, 1961.
- Part 5. Eugene, Oreg., November 8, 1961.
- Part 6. Pocatello, Idaho, November 13, 1961.
- Part 7. Boise, Idaho, November 15, 1961.
- Part 8. Spokane, Wash., November 17, 1961.
- Part 9. Honolulu, Hawaii, November 27, 1961.
- Part 10. Lihue, Hawaii, November 29, 1961.
- Part 11. Wailuku, Hawaii, November 30, 1961.
- Part 12. Hilo, Hawaii, December 1, 1961.
- Part 13. Kansas City, Mo., December 6, 1961.

Housing Problems of the Elderly:**
- Part 1. Washington, D.C., August 22-23, 1961.
- Part 2. Newark, N.J., October 16, 1961.
- Part 3. Philadelphia, Pa., October 18, 1961.
- Part 4. Scranton, Pa., November 14, 1961.
- Part 5. St. Louis, Mo., December 8, 1961.

Nursing Homes:**
- Part 1. Portland, Oreg., November 6, 1961.
- Part 2. Walla Walla, Wash., November 10, 1961.
- Part 3. Hartford, Conn., November 20, 1961.
- Part 4. Boston, Mass., December 1, 1961.
- Part 5. Minneapolis, Minn., December 4, 1961.
- Part 6. Springfield, Mo., December 12, 1961.

Relocation of Elderly People:**
- Part 1. Washington, D.C., October 22-23, 1962.
- Part 2. Newark, N.J., October 26, 1962.
- Part 3. Camden, N.J., October 29, 1962.
- Part 4. Portland, Oreg., December 3, 1962.
- Part 5. Los Angeles, Calif., December 5, 1962.
- Part 6. San Francisco, Calif., December 7, 1962.

- Frauds and Quackery Affecting the Older Citizen:**
  - Part 1. Washington, D.C., January 15, 1963.
  - Part 2. Washington, D.C., January 16, 1963.
  - Part 3. Washington, D.C., January 17, 1963.
- Long-Term Institutional Care for the Aged (Federal programs), Washington, D.C., December 17–18, 1963.**
- Housing Problems of the Elderly:**
  - Part 1. Washington, D.C., December 11, 1963.
  - Part 2. Los Angeles, Calif., January 9, 1964.
  - Part 3. San Francisco, Calif., January 11, 1964.
- Increasing Employment Opportunities for the Elderly:**
  - Part 1. Washington, D.C., December 19, 1963.
  - Part 2. Los Angeles, Calif., January 10, 1964.
  - Part 3. San Francisco, Calif., January 13, 1964.
- Services for Senior Citizens:**
  - Part 1. Washington, D.C., January 16, 1964.
  - Part 2. Boston, Mass., January 20, 1964.
  - Part 3. Providence, R.I., January 21, 1964.
  - Part 4. Saginaw, Mich., March 2, 1964.
- Health Frauds and Quackery:**
  - Part 1. San Francisco, Calif., January 13, 1964.
  - Part 2. Washington, D.C., March 9, 1964.
  - Part 3. Washington, D.C., March 10, 1964.
  - Part 4A. Washington, D.C., April 6, 1964 (eye care).
  - Part 4B. Washington, D.C., April 6, 1964 (eye care).
- Blue Cross and Other Private Health Insurance for the Elderly:**
  - Part 1. Washington, D.C., April 27, 1964.
  - Part 2. Washington, D.C., April 28, 1964.
  - Part 3. Washington, D.C., April 29, 1964.
  - Part 4A. Appendix.
  - Part 4B. Appendix.
- Deceptive or Misleading Methods in Health Insurance Sales, Washington, D.C., May 4, 1964.**
- Nursing Homes and Related Long-Term Care Services:**
  - Part 1. Washington, D.C., May 5, 1964.
  - Part 2. Washington, D.C., May 6, 1964.
  - Part 3. Washington, D.C., May 7, 1964.
- Interstate Mail Order Land Sales:**
  - Part 1. Washington, D.C., May 18, 1964.
  - Part 2. Washington, D.C., May 19, 1964.
  - Part 3. Washington, D.C., May 20, 1964.
- Preneed Burial Service, Washington, D.C., May 19, 1964.**
- Conditions and Problems in the Nation's Nursing Homes:**
  - Part 1. Indianapolis, Ind., February 11, 1965.
  - Part 2. Cleveland, Ohio, February 15, 1965.
  - Part 3. Los Angeles, Calif., February 17, 1965.
  - Part 4. Denver, Colo., February 23, 1965.
  - Part 5. New York, N.Y., August 2–3, 1965.
  - Part 6. Boston, Mass., August 9, 1965.
  - Part 7. Portland, Maine, August 13, 1965.
- Extending Private Pension Coverage:**
  - Part 1. Washington, D.C., March 4, 1965.
  - Part 2. Washington, D.C., March 5 and 10, 1965.

- Services to the Elderly on Public Assistance:**
  - Part 1. Washington, D.C., August 18–19, 1965.
  - Part 2. Appendix.
- The War on Poverty As It Affects Older Americans:**
  - Part 1. Washington, D.C., June 16–17, 1965.
  - Part 2. Newark, N.J., July 10, 1965.
  - Part 3. Washington, D.C., January 19–20, 1966.
- Detection and Prevention of Chronic Disease Utilizing Multiphasic Health Screening Techniques, Washington, D.C., September 20, 21, and 22, 1966.**
- Consumer Interests of the Elderly:**
  - Part 1. Washington, D.C., January 17–18, 1967.
  - Part 2. Tampa, Fla., February 2–3, 1967.
- Tax Consequences of Contributions to Needy Older Relatives, Washington, D.C., June 15, 1966.**
- Needs for Services Revealed by Operation Medicare Alert, Washington, D.C., June 2, 1966.**
- Costs and Delivery of Health Services to Older Americans:**
  - Part 1. Washington, D.C. June 22–23, 1967.
  - Part 2. New York, N.Y., October 19, 1967.
  - Part 3. Los Angeles, Calif., October 16, 1968.
- Retirement and the Individual:**
  - Part 1. Washington, D.C., June 7-8, 1967.
  - Part 2. Ann Arbor, Mich., July 26, 1967.
- Reduction of Retirement Benefits Due to Social Security Increases, Washington, D.C., April 24–25, 1967.**
- Rent Supplement Assistance to the Elderly, Washington, D.C., July 11, 1967.**
- Long-Range Program and Research Needs in Aging and Related Fields, Washington, D.C., December 5–6, 1967.**
- Hearing Loss, Hearing Aids, and the Elderly, Washington, D.C., July 18 and 19, 1968.**
- Adequacy of Services for Older Workers, Washington, D.C., July 24, 25, and 29, 1968.**
- Usefulness of the Model Cities Program to the Elderly:**
  - Part 1. Washington, D.C., July 23, 1968.
  - Part 2. Seattle, Wash., October 14, 1968.
  - Part 3. Ogden, Utah, October 24, 1968.
  - Part 4. Syracuse, N.Y., December 9, 1968.
  - Part 5. Atlanta, Ga., December 11, 1968.
  - Part 6. Boston, Mass., July 11, 1969.
  - Part 7. Washington, D.C., October 14–15, 1969.
- Availability and Usefulness of Federal Programs and Services to Elderly Mexican-Americans:**
  - Part 1. Los Angeles, Calif., December 17, 1968.
  - Part 2. El Paso, Tex., December 18, 1968.
  - Part 3. San Antonio, Tex., December 19, 1968.
  - Part 4. Washington, D.C., January 14–15, 1969.
  - Part 5. Washington, D.C., November 20–21, 1969.

Economics of Aging: Toward a Full Share in Abundance:
  Part 1. Washington, D.C., April 29 and 30, 1969.**
  Part 2. Ann Arbor, Mich., consumer aspects, June 9, 1969.**
  Part 3. Washington, D.C., health aspects, July 17 and 18, 1969.**
  Part 4. Washington, D.C., homeownership aspects, July 31 and August 1, 1969.**
  Part 5. Paramus, N.J., central suburban area, August 14, 1969.***
  Part 6. Cape May, N.J., retirement community, August 15, 1969.***
  Part 7. Washington, D.C., international aspects, August 25, 1969.***
  Part 8. Washington, D.C., national organizations, October 29, 1969.***
  Part 9. Washington, D.C., employment aspects, December 18 and 19, 1969.***
  Part 10A. Washington, D.C., pension aspects, February 17, 1970.***
  Part 10B. Washington, D.C., pension aspects, February 18 1970.***
  Part 11. Washington, D.C., concluding hearing, May 4, 5, and 6, 1970.***
The Federal Role in Encouraging Preretirement Counseling and New Work Lifetime Patterns, Washington, D.C., July 25, 1969.**
Trends in Long-Term Care (Cat. No. Y4.Ag4:C18/Pts.):
  Part 1. Washington, D.C., July 30, 1969.**
  Part 2. St. Petersburg, Fla., January 9, 1970.**
  Part 3. Hartford, Conn., January 15, 1970.**
  Part 4. Washington, D.C. (Marietta, Ohio, fire), February 9, 1970.**
  Part 5. Washington, D.C. (Marietta, Ohio, fire), February 10, 1970.**
  Part 6. San Francisco, Calif., February 12, 1970.***
  Part 7. Salt Lake City, Utah, February 13, 1970.***
  Part 8. Washington, D.C., May 7, 1970.***
  Part 9. Washington, D.C. (Salmonella), August 19, 1970.***
  Part 10. Washington, D.C. (Salmonella), December 14, 1970.***
  Part 11. Washington, D.C., December 17, 1970.***
  Part 12. Chicago, Ill., April 2, 1971.**
  Part 13. Chicago, Ill., April 3, 1971.**
  Part 14. Washington, D.C., June 15, 1971.***
  Part 15. Chicago, Ill., September 14, 1971.***
  Part 16. Washington, D.C., September 29, 1971.***
  Part 17. Washington, D.C., October 14, 1971.***
  Part 18. Washington, D.C., October 28, 1971.***
  Part 19A. Minneapolis-St. Paul, Minn., November 29, 1971.***
  Part 19B. Minneapolis-St. Paul, Minn., November 29, 1971.***
  Part 20. Washington, D.C., August 10, 1972.***
  Part 21. Washington, D.C., October 10, 1973—$1.85.
  Part 22. Washington, D.C., October 11, 1973—$1.65.

Trends in Long-Term Care—Continued
    Part 23. New York, N.Y., January 21, 1975—$2.05.
    Part 24. New York, N.Y., February 4, 1975—$2.40.
    Part 25. Washington, D.C., February 19, 1975—$1.70.
    Part 26. Washington, D.C., December 9, 1975—$2.10.
    Part 27. New York, N.Y., March 19, 1976—$1.20.
Older Americans in Rural Areas:
    Part 1. Des Moines, Iowa, September 8, 1969.***
    Part 2. Majestic-Freeburn, Ky., September 12, 1969.***
    Part 3. Fleming, Ky., September 12, 1969.***
    Part 4. New Albany, Ind., September 16, 1969.***
    Part 5. Greenwood, Miss., October 9, 1969.***
    Part 6. Little Rock, Ark., October 10, 1969.***
    Part 7. Emmett, Idaho, February 24, 1970.***
    Part 8. Boise, Idaho, February 24, 1970.***
    Part 9. Washington, D.C., May 26, 1970.***
    Part 10. Washington, D.C., June 2, 1970.***
    Part 11. Dogbone-Charleston, W. Va., October 27, 1970.***
    Part 12. Wallace-Clarksburg, W. Va., October 28, 1970.***
Sources of Community Support for Federal Programs Serving Older Americans:
    Part 1. Ocean Grove, N.J., April 18, 1970.***
    Part 2. Washington, D.C., June 8–9, 1970.***
Income Tax Overpayments by the Elderly, Washington, D.C., April 15, 1970.**
Legal Problems Affecting Older Americans:
    St. Louis, Mo., August 11, 1970.***
    Boston, Mass., April 30, 1971.***
Evaluation of Administration on Aging and Conduct of White House Conference on Aging:
    Part 1. Washington, D.C., March 25, 1971.***
    Part 2. Washington, D.C., March 29, 1971.***
    Part 3. Washington, D.C., March 30, 1971.***
    Part 4. Washington, D.C., March 31, 1971.***
    Part 5. Washington, D.C., April 27, 1971.***
    Part 6. Orlando, Fla., May 10, 1971.***
    Part 7. Des Moines, Iowa, May 13, 1971.***
    Part 8. Boise, Idaho, May 28, 1971.***
    Part 9. Casper, Wyo., August 13, 1971.***
    Part 10. Washington, D.C., February 3, 1972.***
Cutbacks in Medicare and Medicaid Coverage:
    Part 1. Los Angeles, Calif., May 10, 1971.***
    Part 2. Woonsocket, R.I., June 14, 1971.***
    Part 3. Providence, R.I., September 20, 1971.**
Unemployment Among Older Workers:
    Part 1. South Bend, Ind., June 4, 1971.***
    Part 2. Roanoke, Ala., August 10, 1971.***
    Part 3. Miami, Fla., August 11, 1971.***
    Part 4. Pocatello, Idaho, August 27, 1971.***

- Adequacy of Federal Response to Housing Needs of Older Americans (Cat. No. Y4.Ag4:H81/3 Pts.):
    - Part 1. Washington, D.C., August 2, 1971.***
    - Part 2. Washington, D.C., August 3, 1971.***
    - Part 3. Washington, D.C., August 4, 1971.***
    - Part 4. Washington, D.C., October 28, 1971.***
    - Part 5. Washington, D.C., October 29, 1971.***
    - Part 6. Washington, D.C., July 31, 1972.***
    - Part 7. Washington, D.C., August 1, 1972.***
    - Part 8. Washington, D.C., August 2, 1972.***
    - Part 9. Boston, Mass., October 2, 1972.***
    - Part 10. Trenton, N.J., January 17, 1974.—$1.40.
    - Part 11. Atlantic City, N.J., January 18, 1974—70¢.
    - Part 12. East Orange, N.J., January 19, 1974—65¢.
    - Part 13. Washington, D.C., October 7, 1975—$1.10.
    - Part 14. Washington, D.C., October 8, 1975—$1.50.
- A Barrier-Free Environment for the Elderly and the Handicapped:
    - Part 1. Washington, D.C., October 18, 1971.***
    - Part 2. Washington, D.C., October 19, 1971.***
    - Part 3. Washington, D.C., October 20, 1971.***
- Flammable Fabrics and Other Fire Hazards to Older Americans, Washington, D.C., October 12, 1971 (Cat. No. Y4.Ag4:F61/Pts.)—$1.05.
- Death With Dignity: An Inquiry Into Related Public Issues:
    - Part 1. Washington, D.C., August 7, 1972.***
    - Part 2. Washington, D.C., August 8, 1972.***
    - Part 3. Washington, D.C., August 9, 1972.***
- Future Directions in Social Security (Cat. No. Y4.Ag4:So1/2/Pts.):
    - Part 1. Washington, D.C., January 15, 1973.***
    - Part 2. Washington, D.C., January 22, 1973.***
    - Part 3. Washington, D.C., January 23, 1973.***
    - Part 4. Washington, D.C., July 25, 1973.***
    - Part 5. Washington, D.C., July 26, 1973.***
    - Part 6. Twin Falls, Idaho, May 16, 1974—80¢.
    - Part 7. Washington, D.C., July 15, 1974—$1.55.
    - Part 8. Washington, D.C., July 16, 1974—$1.55.
    - Part 9. Washington, D.C., March 18, 1975—85¢.
    - Part 10. Washington, D.C., March 19, 1975—70¢.
    - Part 11. Washington, D.C., March 20, 1975—70¢.
    - Part 12. Washington, D.C., May 1, 1975—$1.60.
    - Part 13. San Francisco, Calif., May 15, 1975—$1.25.
    - Part 14. Los Angeles, Calif., May 16, 1975—$1.60.
    - Part 15. Des Moines, Iowa, May 19, 1975—$1.10.
    - Part 16. Newark, N.J., June 30, 1975—$1.80.
    - Part 17. Toms River, N.J., September 8, 1975—$1.80.
    - Part 18. Washington, D.C., October 22, 1975—85¢.
    - Part 19. Washington, D.C., October 23, 1975—75¢.
    - Part 20. Portland, Oreg., November 24, 1975—70¢.
    - Part 21. Portland, Oreg., November 25, 1975—85¢.
    - Part 22. Nashville, Tenn., December 6, 1975—90¢.
    - Part 23. Boston, Mass., December 19, 1975—90¢.
    - Part 24. Providence, R.I., January 26, 1976—95¢.
    - Part 25. Memphis, Tenn., February 16, 1976—75¢.

- Fire Safety in Highrise Buildings for the Elderly:
  - Part 1. Washington, D.C., February 27, 1973.***
  - Part 2. Washington, D.C., February 28, 1973.***
- Barriers to Health Care for Older Americans (Cat. No. Y4.Ag4:H34/14/Pts.):
  - Part 1. Washington, D.C., March 5, 1973.***
  - Part 2. Washington, D.C., March 6, 1973.***
  - Part 3. Livermore Falls, Maine, April 23, 1973.***
  - Part 4. Springfield, Ill., May 16, 1973.***
  - Part 5. Washington, D.C., July 11, 1973.***
  - Part 6. Washington, D.C., July 12, 1973—70¢.
  - Part 7. Coeur d'Alene, Idaho, August 4, 1973.***
  - Part 8. Washington, D.C., March 12, 1974—$2.
  - Part 9. Washington, D.C., March 13, 1974—$1.30.
  - Part 10. Price, Utah, April 20, 1974—75¢.
  - Part 11. Albuquerque, N. Mex., May 25, 1974—$1.30.
  - Part 12. Santa Fe, N. Mex., May 25, 1974—95¢.
  - Part 13. Washington, D.C., June 25, 1974—90¢.
  - Part 14. Washington, D.C., June 26, 1974—80¢.
  - Part 15. Washington, D.C., July 9, 1974—$1.55.
  - Part 16. Washington, D.C., July 17, 1974—75¢.
- Training Needs in Gerontology (Cat. No. Y4.Ag4:G31/2/Pts.):
  - Part 1. Washington, D.C., June 19, 1973—$1.20.
  - Part 2. Washington, D.C., June 21, 1973—75¢.
  - Part 3. Washington, D.C., March 7, 1975—50¢.
- Hearing Aids and the Older American:
  - Part 1. Washington, D.C., September 10, 1973.***
  - Part 2. Washington, D.C., September 11, 1973.***
- Transportation and the Elderly: Problems and Progress (Cat. No. Y4.Ag4:T68/Pts.):
  - Part 1. Washington, D.C., February 25, 1974.**
  - Part 2. Washington, D.C., February 27, 1974—90¢.
  - Part 3. Washington, D.C., February 28, 1974.***
  - Part 4. Washington, D.C., April 9, 1974.***
  - Part 5. Washington, D.C., July 29, 1975—75¢.
  - Part 6. Washington, D.C., July 12, 1977—$2.
- Improving Legal Representation for Older Americans (Cat. No. Y4.Ag4:L52/4/Pts.):
  - Part 1. Los Angeles, Calif., June 14, 1974—$1.55.
  - Part 2. Boston, Mass., August 30, 1976—85¢.
  - Part 3. Washington, D.C., September 28, 1976—$1.60.
  - Part 4. Washington, D.C., September 29, 1976—$2.20.
- Establishing a National Institute on Aging, Washington, D.C., August 1, 1974 (Cat. No. Y4.Ag4:N21)—75¢.
- The Impact of Rising Energy Costs on Older Americans (Cat. No. Y4.Ag4:En/Pts.):
  - Part 1. Washington, D.C., September 24, 1974—90¢.
  - Part 2. Washington, D.C., September 25, 1974—75¢.
  - Part 3. Washington, D.C., November 7, 1975—$1.25.
  - Part 4. Washington, D.C., April 5, 1977—$1.80.
  - Part 5. Washington, D.C., April 7, 1977—$2.10.
  - Part 6. Washington, D.C., June 28, 1977—$2.30.

The Older Americans Act and the Rural Elderly, Washington, D.C., April 28, 1975 (Cat. No. Y4.Ag4:R88/2)—$1.35.

Examination of Proposed Section 202 Housing Regulations (Cat. No. Y4.Ag4:H81/Pts.):
  Part 1. Washington, D.C., June 6, 1975—$1.45.
  Part 2. Washington, D.C., June 26, 1975—65¢

The Recession and the Older Worker, Chicago, Ill., August 14, 1975 (Cat. No. Y4.Ag4:R24)—$1.35.

Medicare and Medicaid Frauds (Cat. No. Y4.Ag4:M46/5/Pts.):
  Part 1. Washington, D.C., September 26, 1975—$2.10.
  Part 2. Washington, D.C., November 13, 1975—85¢
  Part 3. Washington, D.C., December 5, 1975—$1.40.
  Part 4. Washington, D.C., February 16, 1976—$1.30.
  Part 5. Washington, D.C., August 30, 1976—$2.10.
  Part 6. Washington, D.C., August 31, 1976—$2.10.
  Part 7. Washington, D.C., November 17, 1976—$1.70.
  Part 8. Washington, D.C., March 8, 1977—$2.40.
  Part 9. Washington, D.C., March 9, 1977—$3.25.

Mental Health and the Elderly, Washington, D.C., September 29, 1975 (Cat. No. Y4.Ag4:M52/3)—$2.10.

Proprietary Home Health Care (joint hearing with the House Select Committee on Aging), Washington, D.C., October 28, 1975 (Cat. No. Y4.Ag4:2/H34/9)—$2.70.

Proposed USDA Food Stamp Cutbacks for the Elderly, Washington, D.C., November 3, 1975 (Cat. No. Y4.Ag4:F73/2)—95¢

The Tragedy of Nursing Home Fires: The Need for National Commitment for Safety (joint hearing with House Select Committee on Aging), Washington, D.C., June 3, 1976.***

The Nation's Rural Elderly (Cat. No. Y4.Ag4:R88/3/Pts.):
  Part 1. Winterset, Iowa, August 16, 1976—$1.90.
  Part 2. Ottumwa, Iowa, August 16, 1976—$1.70.
  Part 3. Gretna, Nebr., August 17, 1976—$1.60.
  Part 4. Ida Grove, Iowa, August 17, 1976—$1.60.
  Part 5. Sioux Falls, S. Dak., August 18, 1976—$2.10.
  Part 6. Rockford, Iowa, August 18, 1976—$1.60.
  Part 7. Denver, Colo., March 23, 1977—$3.75.
  Part 8. Flagstaff, Ariz., November 5, 1977—$1.80.
  Part 9. Tucson, Ariz., November 7, 1977—$2.10.
  Part 10. Terre Haute, Ind., November 11, 1977—$2.10.
  Part 11. Phoenix, Ariz., November 12, 1977—$1.90.
  Part 12. Roswell, N. Mex., November 18, 1977—$2.20.
  Part 13. Taos, N. Mex., November 19, 1977—$2.20.
  Part 14. Albuquerque, N. Mex., November 21, 1977—$2.75.
  Part 15. Pensacola, Fla., November 21, 1977—$2.
  Part 16. Gainesville, Fla., November 22, 1977—$2.10.
  Part 17. Champaign, Ill., December 13, 1977—$2.20.

Medicine and Aging: An Assessment of Opportunities and Neglect, New York, N.Y., October 13, 1976 (Cat. No. Y4.Ag4:M46/7)—$2.10.

Effectiveness of Food Stamps for Older Americans (Cat. No. Y4.Ag4:F73/3/Pts.):
  Part 1. Washington, D.C., April 18, 1977—$1.80.
  Part 2. Washington, D.C., April 19, 1977—$1.50.

Health Care for Older Americans: The "Alternatives" Issue (Cat No. Y4.Ag4:H34/17/Pts.):
  Part 1. Washington, D.C., May 16, 1977—$2.20.
  Part 2. Washington, D.C., May 17, 1977—$2.20.
  Part 3. Washington, D.C., June 15, 1977—$1.80.
  Part 4. Cleveland, Ohio, July 6, 1977—$2.40.
  Part 5. Washington, D.C., September 21, 1977—$2.75.
  Part 6. Holyoke, Mass., October 12, 1977—$2.10.
  Part 7. Tallahassee, Fla., November 23, 1977—$2.10.
  Part 8. Washington, D.C., April 17, 1978.[2]

The Graying of Nations: Implications, Washington, D.C., November 10, 1977 (Cat. No. Y4.Ag4:G79)—$2.75.

Senior Centers and the Older Americans Act, Washington, D.C., October 18, 1977 (Cat. No. Y4.Ag4:Se5/2)—$2.10.

Tax Forms and Tax Equity for Older Americans, Washington, D.C., February 24, 1978 (Cat. No. Y4.Ag4:T19/3)—$1.90.

Medi-Gap: Private Health Insurance Supplements to Medicare (Cat. No. Y4.Ag4:M46/8/Pts.):
  Part 1. Washington, D.C., May 16, 1978—$3.25.
  Part 2. Washington, D.C., June 29, 1978—$2.10.

Retirement, Work, and Lifelong Learning (Cat. No. Y4.Ag4:R31/8/Pts.):
  Part 1. Washington, D.C., July 17, 1978—$2.40.
  Part 2. Washington, D.C., July 18, 1978—$2.10.
  Part 3. Washington, D.C., July 19, 1978—$1.70.
  Part 4. Washington, D.C., September 8, 1978—$2.75.

Medicaid Anti-Fraud Programs: The Role of State Fraud Control Units, Washington, D.C., July 25, 1978.[2]

Vision Impairment Among Older Americans, Washington, D.C., August 3, 1978.***

The Federal-State Effort in Long-Term Care for Older Americans: Nursing Homes and "Alternatives," Chicago, Ill., August 30, 1978.[2]

Condominiums and the Older Purchaser:
  Part 1. Hallandale, Fla., November 28, 1978.[2]
  Part 2. West Palm Beach, Fla., November 29, 1978.[2]

Older Americans in the Neighborhoods:
  Part 1. Washington, D.C., December 1, 1978.[2]
  Part 2. Oakland, Calif., December 4, 1978.[2]

With a request for printed copies of documents, please enclose self-addressed label

---

[2] Not available at time of this printing.

OTHER DOCUMENTS AVAILABLE

Hearings before the Subcommittee on Aging of the U.S. Senate Committee on Labor and Public Welfare, available from the Special Committee on Aging are:

"Amend the Older Americans Act of 1965—S. 2877 and S. 3326," May 24, 25, and June 15, 1966.**

"Older Americans Act Amendments of 1967—S. 951," June 12, 1967.**

"Older Americans Community Service Program—S. 276," September 18 and 19, 1967.**

"White House Conference on Aging in 1970—S.J. Res. 117," March 5–6, 1968.**

"Amending the Older Americans Act of 1965—S. 3677," July 1, 1968.**

"Amending the Older Americans Act of 1965—S. 268, S. 2120, and H.R. 11235," Public Law 91–69, June 19, 1969.***

"Older American Community Service Employment Act—S. 3604"—Fall River, Mass., April 4, 1970; Washington, D.C., June 15–16, 1970.**

"Extended Care Services and Facilities for the Aging," Des Moines, Iowa, May 18, 1970.**

Hearing held by Select Committee on Nutrition and Human Needs, in cooperation with the Senate Special Committee on Aging, Part 14: "Nutrition and the Aged," Washington, D.C., September 9–11, 1969.**

Hearings held by the Subcommittee on Education of the Committee on Labor and Public Welfare, "Education Legislation, 1973—S. 1539," July 11 and 12, 1973. Community School Center Development Act—S. 335.***

With a request for printed copies of documents, please enclose self-addressed label

INDEX

Hearings and reports published by this committee are indexed by the following key:

REPORTS

AAL.—"Action on Aging Legislation in the 95th Congress," committee print, December 1978.

OIT.—Protecting Older Americans Against Overpayment of Income Taxes (A Revised Checklist of Itemized Deductions for Use in Taxable Year 1978)," committee print, December 1978.

PFB.—"The Proposed Fiscal 1979 Budget: What It Means for Older Americans," committee print, February 1978.

POA.—"Paperwork and the Older Americans Act: Problems of Implementing Accountability," committee print, June 1978.

SRO.—"Single Room Occupancy: A Need for National Concern," committee print, June 1978.

HEARINGS

GON.—"The Graying of Nations: Implications," Washington, D.C., November 10, 1977.

HCA.—"Health Care for Older Americans: The 'Alternatives' Issue," part 5, Washington, D.C., September 21, 1977; part 6, Holyoke, Mass., October 12, 1977; part 7, Tallahassee, Fla., November 23, 1977; part 8, Washington, D.C., April 17, 1978.

MAP.—"Medicaid Anti-Fraud Programs: The Role of State Fraud Control Units," Washington, D.C., July 25, 1978.

MGI.—"Medi-Gap: Private Health Insurance Supplements to Medicare," parts 1 and 2, Washington, D.C., May 16 and June 29, 1978.

NRE.—"The Nation's Rural Elderly," part 8, Flagstaff, Ariz., November 5, 1977; part 9, Tucson, Ariz., November 7, 1977; part 10, Terre Haute, Ind., November 11, 1977; part 11, Phoenix, Ariz., November 12, 1977; part 12, Roswell, N. Mex., November 18, 1977; part 13, Taos, N. Mex., November 19, 1977; part 14, Albuquerque, N. Mex., November 21, 1977; part 15, Pensacola, Fla., November 21, 1977; part 16, Gainesville, Fla., November 22, 1977; part 17, Champaign, Ill., December 13, 1977.

RWL.—"Retirement, Work, and Lifelong Learning," parts 1, 2, 3, and 4, Washington, D.C., July 17, 18, 19, and September 8, 1978.

SCA.—"Senior Centers and the Older Americans Act," Washington, D.C., October 20, 1977.

TFE.—"Tax Forms and Tax Equity for Older Americans," Washington, D.C., February 24, 1978.

VIA.—"Vision Impairment Among Older Americans," Washington, D.C., August 3, 1978.

A

Page

- Abeyta, Joseph F., Sr., National Indian Council on Aging, statement — NRE 1035
- Acosta, Cruz, project director, Eddy County Community Action Senior Citizens Nutrition Program, Artesia, N. Mex., statement — NRE 969
- ACTION, older American volunteer programs, recent legislation — AAL 16
- Administration on Aging:
  - Data collection, problems of reporting systems — POA 6
  - Elderly programs, consolidation recommended — NRE 770
  - Expansion and strengthening suggested — HCA 654
  - Paperwork:
    - Compliance documents — POA 26
    - Issuance system — POA 27
  - Program funding continued — PFB 1
  - Reporting systems, recommendations for augmenting — POA 16
  - Reilly, Donald F., Deputy Commissioner, statement — SCA 7
- Advent Christian Home, Dowling Park, Live Oak, Fla., statement of J. Pomeroy Carter — HCA 723
- Age Discrimination Act:
  - Amendments to — AAL 1
  - Recent changes — RWL 114
- Aguilar, Irene, director, Otero County Nutrition Program for the Elderly, Alamogordo, N. Mex., statement — NRE 962
- Ahrens, Robert J., National Council on the Aging, Inc., statement — RWL 221
- Alexander, Mayor Neel, Belen, N. Mex., letter — NRE 988
- American Institutes for Research, statement of Dr. Harold L. Sheppard — RWL 54
- American Public Health Association, statement of Dr. Philip G. Weiler — HCA 528
- American Optometric Association, Washington, D.C., statement — VIA 52
- Ami, Alexander W., director, Hopi Tribal Bureau on Aging, Oraibi, Ariz.:
  - Resolution — NRE 889
  - Statement — NRE 856
- Amyx, Eugene R., chairman, Central Florida Chapter, National Council of Senior Citizens, statement — HCA 750
- Anderson, Dr. Egbert V., director Santa Rosa County, Fla., Health Department, statement — NRE 1255
- Anderson, Eunice P., Tallahassee, Fla., statement — HCA 761
- Anderson, Sir Ferguson, University of Glasgow, Scotland:
  - Lecture — GON 49
  - Statement — GON 14
- Anderson, John W., Community and Regional Opportunity Program, Inc., Chicopee, Mass., statement — HCA 705
- Anderson, Wanda F., research associate, Southern Illinois University, Carbondale, Ill., statement — NRE 1436
- Ankeny, Arthur A., executive director, Senior Activities Center of Cambria County, Inc., Johnstown, Pa., letter — SCA 60
- Ansak, Marie-Louise, On Lok Senior Health Services, San Francisco, Calif., statement — HCA 561
- Anthony, Amy, director, Springfield, Mass., Housing Allowance Program, Inc., statement — HCA 677
- Aragon, Secundino, chairman, Mora-San Miguel County, N. Mex., Advisory Boards, statement — NRE 1043
- Arellano, Margarito, mayor, Springer, N. Mex., letter — NRE 1078
- Arizona Council of Senior Citizens, statement of Catherine Steinhauser Knowles, president — NRE 604
- Ascoli, Marian L., telecare program director, Family Service of Champaign County, Urbana, Ill.:
  - Profile of black aged — NRE 1454
  - Recommendations, guidelines — NRE 1452
  - Statement — NRE 1407
- Aslan, Prof. Ana, Director, National Institute of Gerontology and Geriatrics, Bucharest, Romania, statement — GON 17
- Asociacion Nacional Pro Personas Mayores, statement of Carmela G. Lacayo, executive director — RWL 291
- Association for Gerontology in Higher Education, statement of Dr. Mildred M. Seltzer, president — RWL 296

NOTE: See page 221 for guide to code abbreviations.

B

Page

Babson, Stanley M., Jr., management consultant, Technicon Corp., New Canaan, Conn.:
  Letter RWL 213
  Statement RWL 186
Bach, Mary M., attorney, Center for Public Representation, Madison, Wis., statement MGI 162
Bankers Life & Casualty Co. of Illinois:
  Grubbs, William E., statement MGI 53
  Letter, papers MGI 143
Barela, Cayetano, assistant regional coordinator, Association Nacional Pro Personas Mayores, Albuquerque, N. Mex., statement NRE 1136
Barkstall, Vernon L., executive director, Urbana League of Champaign County, Champaign, Ill., statement NRE 1444
Bart, Irving, Tucson, Ariz., statement NRE 734
Barton, Donald W., Loomis House Development Program, Holyoke, Mass., statement HCA 706
Baxter, Jesse, Winslow Council on Aging, Winslow, Ariz., statement NRE 674
Beal, Frank S., Health Care Financing Administration, HEW:
  Letter MAP 40
  Statement MAP 3
Beall, Mary Elsie, foster grandparent program, Gainesville, Fla., statement NRE 1362
Beattie, Walter M., Jr., director, All-University Gerontology Center Syracuse University, paper GON 155
Bechtel, David, chairman, West Valencia County, N. Mex., Advisory Board:
  Proposal NRE 1219
  Statement NRE 1104
Bedford, Gwen, Arizona Council for Senior Citizens, statement NRE 740
Beers, Robert M., vice president, National Association of Retired Federal Employees, statement RWL 357
Begay, Lucy T., Chinle, Ariz., statement NRE 887
Bell, Dr. William G., director, Multi-disciplinary Center on Gerontology, Florida State University, statement HCA 729
Benecke, Herman A., Pensacola, Fla., statement NRE 1275
Bennes, Cornelius, Rio Rancho, N. Mex., statement NRE 1111
Bernal, Paul, tribal spokesman, Taos Pueblo, Taos, N. Mex., statement NRE 1076
Bia, Maria, supervisor, National Council on the Aging Program, Fort Defiance, Ariz., statement NRE 886
Binns, Lucien E., president, Roswell, N. Mex., local, National Association of Retired Federal Employees, statement NRE 926
Bissel, Byron L., Arizona Department of Economic Security, Bisbee, Ariz., statement NRE 738
Blakeley, Anne E., liaison assistant, National Indian Council on Aging:
  Letter RWL 349
  Statement RWL 321
Block, James H., executive director, Region VI Housing Authority, Roswell, N. Mex., statement NRE 988
Blocker, Beatrice, chairperson, Area Agency on Aging Advisory Board, Artesia, N. Mex., statement NRE 971
Blocker, Gary N., mayor, Jal, N. Mex., letter NRE 1244
Bloomer, Janie L., Rocky Bar Farm, Hardin, Ill., statement NRE 1459
Blumenthal, Morton, executive director, New England Nonprofit Housing Development Corp., Concord, N.H., statement HCA 682
Bourlière, Prof. Francois, Inserm Gerontology Research Unit, Paris, France, statement GON 29
Boyd, Grace, president, Conconino Council on Aging, Flagstaff, Ariz., statement NRE 660
Brede, Jack, North Central Florida Health Planning Council, Inc., Gainesville, Fla., statement NRE 1357
Brickfield, Cyril, executive director, National Retired Teachers Association/American Association of Retired Persons:
  Letter SCA 64
  Statement RWL 236

NOTE: See page 221 for guide to code abbreviations.

Page

- Briggs, Robert E., administrator, St. Mary's Hospital, Roswell, N. Mex., statement .... NRE 940
- Briggs, Warren M., mayor, Pensacola, Fla.:
  - Letter .... NRE 1305
  - Statement .... NRE 1258
- Brooke, Senator Edward W., statement .... HCA 633
- Brotman, Herman, consultant, Senate Special Committee on Aging, statement .... RWL 327
- Brown, Dr. Arnold S., gerontologist, Northern Arizona University, statement .... NRE 683
- Brown, Evelyn, director, Hobbs Community Center, Hobbs, N. Mex., statement .... NRE 967
- Brown, Rev. Lewis, Pensacola, Fla., statement .... NRE 1271
- Brown, William M., president, Tri-County Council on Aging, Old Town, Fla., statement .... NRE 1327
- Browne, Margaret P., director, Los Alamos, N. Mex., Family Council, Inc., letter .... NRE 1078
- Buck, Joann, executive director, Share Your Care, Inc., Albuquerque, N. Mex.:
  - Letter .... NRE 1225
  - Statement .... NRE 1177
- Burke Rehabilitation Center Day Hospital, White Plains, N.Y.:
  - Recommendations listed by .... HCA 516
  - Report by .... HCA 519
  - Statement of Charlotte Hamill, codirector .... HCA 515
- Butler, Farley P., vice president, Alachua General Hospital, Gainesville, Fla.:
  - Letter .... NRE 1375
  - Statement .... NRE 1359
- Butler, Dr. Robert, Director, National Institute on Aging:
  - Guest editorial .... GON 88
  - Statement .... GON 10
- Byrne, John, president, National Association of Home Health Agencies, St. Louis, Mo.:
  - Letter .... HCA 857
  - Testimony .... HCA 808

C

- Cain, Carol Sue, director, Senior Center, Winslow, Ariz., statement .... NRE 672
- Caldwell, Laura, technical counselor, Florida green thumb program, De Funiak Springs, Fla., statement .... NRE 1272
- Califano, Hon. Joseph A., Secretary, Department of Health, Education, and Welfare:
  - Response to questions .... RWL 70
  - Statement .... RWL 6
- California Department of Insurance, policy regulation decision .... MGI 183
- Callahan, Dr. James J., Jr., secretary, Massachusetts Department of Elder Affairs, statement .... HCA 660
- Campbell, Hon. Alan K., Chairman, Civil Service Commission:
  - Letter .... RWL 208
  - Statement .... RWL 177
- Campbell, Marion H., director, Florida green thumb program, Jacksonville Beach, Fla., statement .... NRE 1343
- Candelaria, Esther Hernandez, Albuquerque, N. Mex., statement .... NRE 1234
- Carlson, Louise, program director, Los Alamos, N. Mex., letter .... NRE 1078
- Carroll, Charles F., area supervisor, NRTA/AARP, St. Petersburg, Fla., statement .... NRE 1349
- Carter, J. Pomeroy, Advent Christian Home, Dowling Park, Live Oak, Fla., statement .... HCA 723
- Caserta, Joan E., National League for Nursing, New York City:
  - Letter .... HCA 855
  - Paper .... HCA 829
  - Statement .... HCA 791

NOTE: See page 221 for guide to code abbreviations.

Page

Cazares, Hon. Gabriel, mayor, Clearwater, Fla., statement HCA 636
Central Virginia Commission on Aging, statement of Wallace Clair, director SCA 11
Century, Fla., informal discussions NRE 1279
Community Education and Training Act, funding outlays projected, statistics PFB 10
Chavez, Del G., metro nutrition program, Albuquerque, N. Mex., statement NRE 1184
Cheatham, Wiley L., district attorney, Cuero, Tex., statement MGI 220
Chebotarev, Prof. Dmitri F., Director, Institute of Gerontology of the U.S.S.R Academy of Medical Sciences, Kiev, U.S.S.R.:
  Paper GON 55
  Statement GON 19
Chiles, Senator Lawton, statements GON 5, HCA 483, 711, 800, MGI 1, 211, NRE 1249, 1311, RWL 120, SCA 1
Chino, Wendell, president, Mescalero Apache Tribe of New Mexico, statements NRE 1072, 1117
Christianson, Barbara, mayor, Corrales, N. Mex., letter NRE 1243
Church, Senator Frank:
  Letters MAP 37, 42, 45, RWL 69, 83, 153, 168, 207, 212, 216
  Statements GON 3, MAP 1, RWL 1, 111, 219, SCA 2, TFE 1, VIA 1
Civil Service Commission:
  Campbell, Hon. Alan K., Chairman, statement RWL 177
  Tinsley, Thomas A., Director, Bureau of Retirement, Insurance, and Occupational Health, testimony RWL 182
Clague, Ewan, former Commissioner, Bureau of Labor Statistics:
  Letter RWL 168
  Statement RWL 135
Clair, Wallace, National Association of Area Agencies on Aging, statement SCA 11
Clark, John B., executive director, Escambia County, Fla., Council on Aging, Inc., statement NRE 1264
Cody, Kenneth, Sr., president, Navajo Nation Council on Aging NRE 1197
Cody, Sarah, executive director, Visting Nurses Association, Inc., Holyoke, Mass., statement HCA 674
Cohen, Rennie, North West law project, Philadelphia, Pa., letter SCA 61
Cohen, Representative William S., statement HCA 786
Colenbrander, Dr. August, medical director, Pacific Medical Center's Low Vision Service, San Francisco, Calif., statement VIA 5
Colorado River Indian Tribes, statement NRE 898
Community education programs, proposed increase for PFB 12
Community Services Administration, funding of programs listed PFB 9
Conaway, Margaret A., Golden Age Clubs of Niagara Falls, Inc., letter SCA 56
Cone, Virgie, director, District 3 Area Agency on Aging, Jasper, Fla., statement NRE 1321
Connecticut State Insurance Commission, statement of Joseph C. Mike MGI 245
Conroy, Shirley, director, retired senior volunteer program, Gainesville, Fla., statement NRE 1361
Cooney Claire Haaga, Vera Institute's easyride program, New York City:
  Letter HCA 586
  Statement HCA 552
Cooper, W. W., Office of Florida Insurance Commissioner, statement MGI 85
Cordell, Eursell, national field vice president, National Association of Retired Federal Employees, statement NRE 1142
Cordero, Andrew, Coconino County, Ariz., Community Services, statement NRE 656
Cordova, Gustavo, chairman, Taos-Rio Arriba County, N. Mex., Advisory Board statement NRE 1045
Cottrell, Marion, chairman, Middle Rio Grande Council of Governments, Albuquerque, N. Mex.:
  Letter NRE 1222
  Statement NRE 1158

Note: See page 221 for guide to code abbreviations.

Page
Cournoyer, Terry, Community and Regional Opportunity Program, Inc., Chicopee, Mass., statement .... HCA 705
Cox, Dr. Harold, department of sociology, Indiana State University, Terre Haute, Ind., statement .... NRE 801
Cox, Jean, director, Area Agency on Aging, Terre Haute, Ind., statement .... NRE 770
Cruikshank, Nelson H., president, National Council of Senior Citizens, Inc., paper .... RWL 342
Curley, Larry, specialist, National Indian Council on Aging, statement .... RWL 352
Czechoslovakia, Prague:
  Geriatric nurse services described .... GON 22
  Statement of Dr. Hana Hermanova, Scientific Secretary, Third Medical Clinic .... GON 21

D

Danstedt, Rudolph T., National Council of Senior Citizens, statement.. RWL 279
Davis, Dolores, executive director, National Caucus on the Black Aged, Inc., statement .... RWL 305
Davisville, Fla., informal discussions .... NRE 1291
De Agostino, James, associate administrator, Eastern New Mexico Medical Center, Roswell, N. Mex., statement .... NRE 938
Deaux, Barbara, director, Health and Social Services, Eight Northern Indian Pueblos Council, San Juan Pueblo, N. Mex., statement.. NRE 1030, 1065
DeConcini, Senator Dennis, statements .... NRE 643, 693, 843
De Hart, Lena, Wickenburg, Ariz., statement .... NRE 730
Delego, Billie R., De Funiak Springs, Fla., statement .... NRE 1273
Demby, Dorothy, American Foundation for the Blind, Inc., New York City, letter .... VIA 46
Denmark, Copenhagen:
  Elderly surveys instituted .... GON 33
  Statement of Henning Friis, Executive Director, National Institute of Social Research .... GON 33
Derzon, Robert, Administrator, Health Care Financing Administration, HEW:
  Letter .... HCA 579
  Statement .... HCA 491
DeVault, Myrtle M., Brazil, Ind., statement .... NRE 799
De Vore, John, Northern Arizona Council of Governments, statement.. NRE 652
Dobbratz, Theodore R., Lutheran Brotherhood Securities Corp., Terre Haute, Ind., statement .... NRE 798
Doherty, Dr. Anne, Katherine Hamilton Community Mental Health Center, Terre Haute, Ind., statement .... NRE 777
Doherty, Dr. Neville, research director, Project Triage, Inc., University of Connecticut, statement .... HCA 504
Dole, Hon. Elizabeth Hanfold, Commissioner, Federal Trade Commission, statement .... MGI 234
Domenici, Senator Pete V., statements .... GON 1, HCA 785, MGI 27, 212, NRE 903, 994, 1087, RWL 4, SCA 3
Donohoe, Msgr. Robert J., chairman, Governor's Advisory Committee on Aging, Phoenix, Ariz., statement .... NRE 844
Dulgov, Gloria, director, Senior NOW Generation Program, Tucson, Ariz., statement .... NRE 708
Duncan, Sadie Pearl, director, Area Agency on Aging, Yuma, Ariz., letter .... NRE 687
Dunn, Ed, director, Northern Arizona Council of Governments, Flagstaff, Ariz., statement .... NRE 645
Duran, Barela, Senior Citizens Center, Winslow, Ariz., statement .... NRE 673
Durant, Randall, director, Senior Citizens Programs, Gila River Indian Community, Sacaton, Ariz., statement .... NRE 854
Dwight, Maria B., vice president, Gerontological Planning Associates, Santa Monica, Calif., statement .... HCA 648

NOTE: See page 221 for guide to code abbreviations.

E

Elderly: — Page
- Blindness, definitions vary — VIA 5
- Crimes against — NRE, 809, 814
- Day care centers, importance of — HCA 639
- Duplication of program services — SCA 21
- **Early retirement trend — RWL 33**
- **Education, poverty, tables — RWL 308**
- **Educational opportunities, low participation questioned — RWL 300**
- **Employment:**
  - **Decreasing rate evident — RWL 265**
  - **Discrimination persists — RWL 284**
  - **Disincentives evident — RWL 303**
  - **Flexitime encouraged — RWL 180**
  - **Forced retirement, criticisms of — RWL 240**
  - **Higher productivity cited — RWL 324**
  - **Improvements evident — RWL 130**
  - **Incentives necessary — RWL 263**
  - **NCOA recommendations — RWL 235**
  - **Prejudice versus education — RWL 329**
  - **Rate table — RWL 266**
  - **Recent legislation — AAL 2**
  - **Retraining programs cited — RWL 64**
  - **Society, attitudes changing — RWL 299**
  - **Survey results, NCOA — RWL 224**
  - **Title IX, value cited — RWL 234**
- Eye diseases, descriptions of — VIA 6
- Family concern, survey cited — GON 42
- Family role important — GON 28
- Food stamps, participation increase, statistics — PFB 12
- Geriatric medicine, specialty in — GON 44
- Health care:
  - Alternatives to hospitalization lacking — HCA 754
  - Assessment and referral systems necessary — HCA 546
  - Assessment teams utilized — HCA 542
  - Billing procedure criticized — HCA 812
  - Case management essential — HCA 653
  - Community interest — HCA 554, 661
  - Cooperation among agencies necessary — HCA 550
  - Costs alarming — HCA 666
  - Cost-plus reimbursement criticized — HCA 815
  - Depression: and important factor — NRE 778
  - "Doctor shipping" — HCA 558
  - Drug addiction, inadvertent — HCA 557
  - Experimental project cited — HCA 532
  - Families, pressure evident — RWL 58
  - Financial burden is major concern — HCA 743
  - Funding:
    - Local matching deficient — HCA 640
    - More stringent guidelines suggested — HCA 641
  - HEW:
    - Performance criticized — HCA 573
    - Program timetable promised — HCA 498
    - Research — HCA 488
    - Studies — HCA 487
  - Illnesses more acute — HCA 716
  - Inadequacies of — HCA 485
  - Inflation: a major problem — HCA 762
  - Institutional planning deficient — HCA 798
  - Manpower shortage evident — HCA 559
  - National assessment needed — HCA 806
  - Needs survey conducted — RWL 24
  - New standards cited — HCA 789
  - New training manual — HCA 808
  - Nurses, use of emphasized — HCA 749

NOTE: See page 221 for guide to code abbreviations.

Elderly—continued

- Health care—continued — Page
  - Nursing homes versus day care, costs compared .... HCA 545
  - Out-patient placement difficult .... HCA 756
  - Oversedation: path of least resistance .... HCA 738
  - Physicians unprepared .... HCA 745
  - Problems classified .... HCA 529
  - Program coordination needed .... HCA 652
  - Proprietary agencies, licensing difficulties .... HCA 807
  - Reasonable costs possible .... HCA 562
  - Rural doctors declining .... NRE 644
  - Screening units needed .... NRE 704
  - Services, definitions vary .... HCA 805
  - Standards, adherence to .... HCA 797
  - Standards enforcement discussed .... HCA 811
  - State limitations cited .... HCA 802
  - Support system critical .... HCA 549
  - Telephone reassurance, importance of .... HCA 814
  - Title XX expenditures listed .... HCA 804
  - Transportation: a continuing problem .... HCA 657
  - Unanswered questions .... HCA 493
  - "Warehousing" in nursing homes .... HCA 637
- Health insurance:
  - Advertising techniques, illustrations .... MGI 21
  - Company policy cited .... MGI 66
  - Company practices questioned, case history .... MGI 31
  - Company standards exceeded .... MGI 68
  - Fraudulent solicitations, examples .... MGI 219
  - "Goose list," examples .... MGI 227
  - New provisions initiated .... MGI 50
  - New State requirements .... MGI 78
  - Overpurchasing .... NRE 668
  - Overselling of policies .... MGI 72
  - Problems in buying, news articles .... MGI 5
  - Sales practices, unethical .... MGI 216
  - Total coverage nonexistent .... MGI 76
  - Underwriting, unethical practices .... MGI 77
- Hispanic, unique problems .... RWL 292
- Home care:
  - Emphasis on .... GON 39
  - Income restriction criticized .... HCA 667
  - National study undertaken .... HCA 673
  - Sliding scale suggested for eligibility .... HCA 667
  - Unmet needs .... HCA 672
- Home care corporations:
  - Importance of .... HCA 662
  - Services provided by .... HCA 662
- Home repair, problems cited .... NRE 659
- Housing:
  - Budget funding levels .... PFB 7
  - Deterioration: elderly first victims .... HCA 679
  - Federal housing assistance plan .... SRO 25
  - Goals and patterns .... SRO 24
  - HUD ruling criticized .... NRE 775
  - Objective: independent living .... HCA 680
  - Rent subsidies, importance of .... HCA 678
  - Supportive services necessary .... SRO 31
  - Urban renewal, problems caused by .... SRO 4
- Income comparisons, table .... RWL 280
- Indiana:
  - Services inadequate .... NRE 848
  - Volunteer experts, training by .... NRE 920

NOTE: See page 221 for guide to code abbreviations.

Elderly—continued

Page

- Indians:
  - Housing deficiencies NRE 863
  - Problems more intense NRE 845
  - Progress slow NRE 846
  - Services delivery impeded NRE 851
  - Tribal pride toward elders NRE 857
- Inflation:
  - Effect of RWL, 136, 243
- Lifelong learning program, effect limited RWL 286
- Long-term care, administrative focal point questioned HCA 494
- Mental health:
  - Obstacles to services noted NRE 779
  - Programs limited HCA 672
  - Public "conspiracy" NRE 777
- Nursing homes:
  - Medicaid reimbursement gaps HCA 725
  - Medicare patients excluded HCA 751
- Nutrition:
  - Emergency care, importance of HCA 668
  - Facilities not fully utilized HCA 727
  - Program expansion AAL 10
- Pension plans, underfunding RWL 8
- Population:
  - Percentage increasing RWL 238
  - Projections:
    - Charts GON 7
    - Tables RWL 238
  - Trends cited RWL 6
- Program coordination of resources needed SCA 9
- Program funding, 6-month delays NRE 654
- Retirement:
  - Civil service, recent legislation AAL 1
  - Cost-of-living adjustment RWL 143
  - Deferral incentives suggested RWL 12
  - Effect of GON 47
  - Incentives to defer RWL 59
  - Inflation, impact RWL 36
  - News articles RWL 360
  - Pension plans, integration of RWL 17
  - Pension plans, mismanagement RWL 117
  - Recent trends RWL 11
- Rural:
  - Health services unavailable, case history NRE 676
  - Legal aid, funding NRE 664
  - Legal services:
    - Inaccessible NRE 647
    - Shortage NRE 666
  - Programs, funding disproportionate NRE 648
  - Providing own services NRE 670
  - Services hampered by isolation NRE 718
  - Transportation, key issue to services NRE 773
- Security: a primary concern HCA 726
- Senior centers:
  - Accreditation discussed SCA 37
  - Area funding SCA 13
  - Background information SCA 41
  - Block grants SCA 33
  - Definition of SCA 7
  - Funding of SCA 5
  - Growth noted SCA 8
  - Importance emphasized NRE 766, SCA 4

NOTE: See page 221 for guide to code abbreviations.

- Elderly—Continued
  - Senior centers—continued
    - Page
    - Physicians donate time ... SCA 24
    - Services offered by ... SCA 15
    - Surveys conducted ... SCA 30
    - Table ... PFB 1
    - Values cited ... RWL 38
  - Service programs, bureaucratic bias ... RWL 321
  - Service providers, education of ... GON 41
  - Single room occupancy:
    - Desirability of, reasons cited ... SRO 6
    - Federal programs discourage ... SRO 7
    - Future discussed ... SRO 22
    - Lifestyle, preservation of ... SRO 8
    - Limited community response ... SRO 3
    - Outreach services, mandated ... SRO 9
    - Residents fearful, distrustful ... SRO 8
  - Social services, increased funding authorization ... AAL 15
  - Taxes:
  - Administration proposals ... TFE 28
    - Itemized deductions, checklist of ... OIT 1
    - Means test criticized ... TFE 43
    - Relief cited ... TFE 3
    - Tax Reduction and Simplification Act ... AAL 17
  - Training, recent legislation ... AAL 2
  - Transportation:
    - Recent legislation ... AAL 19
    - Urban Mass Transportation Administration, grants by ... PFB 11
  - Veterans' benefits, projections, table ... PFB 10
  - Visual impairment:
    - Aids suggested ... VIA 10
    - Demonstrations conducted ... VIA 19
    - Followup programs needed ... VIA 19
    - Funding, critical issue ... VIA 31
    - Increasing, reasons for ... VIA 18
    - Library services underutilized ... VIA 32
    - Rehabilitation programs needed ... VIA 29
    - Statistics ... VIA 9
    - Success in treating, case history ... VIA 17
- Employment, women, nontraditional job placement ... RWL 233
- Endwright, Maurice, executive director, Indian Commission on the Aging and Aged, Indianapolis, Ind., statement ... NRE 765
- Energy:
  - National Energy Act ... AAL 4
  - Tax credit cited ... TFE 12
  - Weatherization program funding limited ... NRE 657
- Energy, Department of, weatherization, emphasis on ... PFB 10

F

- Farthing, Gladys, president, golden circle nutrition program, Effingham, Ill., letter ... NRE 1459
- Federal Trade Commission:
  - Policy planning issues paper ... MGI 275
  - Statement of Hon. Elizabeth Hanford Dole, Commissioner ... MGI 234
- Feiler, Raymond A., vice president, Indiana Taxicab Operators Association, Terre Haute, Ind., statement ... NRE 833
- Felling, Darrell, State representative, Terre Haute, Ind., statement ... NRE 793
- Finn, June, title VII project director, Danville, Ill., statement ... NRE 1440

NOTE: See page 221 for guide to code abbreviations

Page
Fitzgerald, Shirley M., president, Indiana Association of Senior Centers, letter NRE 825
Flesher, Linda Sharp, coordinator, Home Health Services, Champaign County Nursing Home, Urbana, Ill., statement NRE 1442
Florida:
  Council on Aging, Tallahassee, Fla., statement of Margaret H. Jacks, legislative liaison HCA 742
  Division of Blind Services, Tallahassee, Fla., statement of Donald H. Wedewer, director VIA 29
  Insurance Commission, statement of W. W. Cooper MGI 85
  Office on Aging and Adult Services, Tallahassee, Fla., statement of E. Bentley Lipscomb, program staff director HCA 713, SCA 4
  Retired Teachers Association/Association of Retired Persons, statement of Dr. Ed Henderson HCA 749
  State Hospital, Chattahoochee, Fla., statement of Winsor Schmidt HCA 752
  State legislature, report from HCA 718
Florida, University of:
  Bell, Dr. William G., director, Multidisciplinary Center on Gerontology, statement HCA 729
  Reynolds, Dr. Richard C., chairman, Department of Community Health and Family Medicine, statement NRE 1312
  Riker, Prof. Harold C., Counselor Education Department, statement NRE 1364
Fogarty International Center, HEW, statement of Dr. Milo Leavitt, Director GON 87
Folk, Peggy, director, District 1 Area Agency on Aging, N. Mex., statement NRE 1167
Food stamps, participation increase, statistics PFB 12
Forman, Dr. Bernard I., representative, National Gray Panthers, Washington, D.C., statement RWL 288
Forrester, Mary, board of directors, Holyoke-Chicopee (Mass.) Home Care Corp., statement HCA 654
Forsman, Marion, president, Alachua County Older Americans Council, Inc., Gainesville, Fla., statement NRE 1339
France:
  Elderly research programs cited GON 29
  Statement of Prof. Francois, Bourlière, Inserm Gerontology Research Unit, Paris GON 29
Freeman, S. M. "Mike," Florida Department of Health and Rehabilitation Services, Pensacola, Fla., statement NRE 1266
Fresquez, Annabelle, Action director, senior citizens program, Taos and Rio Arriba Counties, N. Mex., statement NRE 1002
Friedman, Gerald R., director, Retina Associates, Boston, Mass., statement VIA 12
Friis, Henning, Executive Director, National Institute of Social Research, Copenhagen, Denmark, statement GON 33
Frost, J. Michael, administrator, Memorial Osteopathic Hospital, Roswell, N. Mex., statement NRE 941

G

Gallegos, Joseph M., Albuquerque, N. Mex., statement NRE 1214
Garcia, Manuel A., Jr., superintendent, New Mexico Department of Insurance, statement MGI 262
Gashel, James, National Federation of the Blind, Washington, D.C., letter VIA 45
Gee, Dr. William, On Lok Senior Health Services, San Francisco, Calif., statement HCA 571
George, Bob, executive director, division of social welfare, Navajo Tribe, Window Rock, Ariz., statements NRE 870, 1194
Gerontological Planning Associates, Santa Monica, Calif., statement of Maria B. Dwight, vice president HCA 649

NOTE: See page 221 for guide to code abbreviations.

Page

Gerontology Society, statement of Ed Kaskowitz, executive director — RWL 317
Gilmore, Jewell P., Pensacola, Fla., statement — NRE 1274
Glenn, Senator John, statement — MGI 28
Gomez, Cora, senior citizens program director, Administration for Native Americans, Jicarilla Apache Tribe, N. Mex., statement — NRE 1029
Grabel, Stewart, director, Cochise senior nutrition project, Douglas, Ariz., statement — NRE 705
Gregory, Oscar W., chairman, Colfax County, N. Mex., Advisory Board, statement — NRE 1042
Grossetete, Ginger, mayor's office for senior citizens, Albuquerque, N. Mex., statement — NRE 1100
Grubbs, William E., director of government relations, Bankers Life & Casualty Co., Chicago, Ill., statement — MGI 53
Gunnoe, Joann, coordinator, gerontology services, Mental Health Center, Gainesville, Fla., statement — NRE 1363
Gunter, Pat L., director, Williamson County Programs on Aging, Herrin, Ill., statement — NRE 1416

H

Hacking, James, assistant legislative counsel, NRTA/AARP, Washington, D.C., statement — TFE 26
Hall, Hadley, San Francisco, Calif., Home Health Service:
  Letter — HCA 603
  Paper — HCA 821
  Response to questions — HCA 605
  Statements — HCA 572, 789
Halvorson, Richard, director, Sandy Senior Center, Sandy, Oreg., statement — SCA 18
Hamill Charlotte, codirector, Burke Rehabilitation Center Day Respital, White Plains, N.Y., statement — HCA 515
Hamilton, Philip, Pima County Health Department, Tucson, Ariz., statement — NRE 729
Hanga, Delores, director, Hualapai nutrition project, Peach Springs, Ariz., statement — NRE 863
Harlem, Dr. Gudmund, medical director, Institute of Medical Rehabilitation, Oslo, Norway, statement — GON 24
Harris, Mrs. O. B., Buckeye, Ariz., statement — NRE 733
Hays, Mary Ellen, Wickenburg, Ariz., statement — NRE 731
Health care:
  Alternatives to hospitalization lacking — HCA 754
  Assessment and referral systems necessary — HCA 546
  Assessment teams utilized — HCA 542
  Billing procedure criticized — HCA 812
  Case management essential — HCA 653
  Community interest — HCA 554, 661
  Cooperation among agencies necessary — HCA 550
  Cost-plus reimbursement criticized — HCA 815
  Costs alarming — HCA 666
  Costs, table — RWL 22
  "Doctor shopping" — HCA 558
  Drug addiction, inadvertent — HCA 557, NRE 795
  Experimental project cited — HCA 532
  Financial burden is major concern — HCA 743
  Funding:
    Local matching deficient — HCA 640
    More stringent guidelines suggested — HCA 641
  HEW:
    Performance criticized — HCA 573
    Program timetable promised — HCA 498
    Research — HCA 488
    Studies — HCA 487
  Inadequacies of — HCA 485

Note: See page 221 for guide to code abbreviations.

Health care—continued
Page
Inflation: A major problem
Illnesses more acute ---- HCA 762
Institutional planning deficient ---- HCA 716
Maintenance organizations ---- HCA 798
Manpower shortage evident ---- RWL 26
Medicare-Medicaid Anti-Fraud and Abuse Amendments ---- HCA 559
Medi-set: medication dispensing device ---- AAL 5
National assessment needed ---- NRE 946
Needs survey conducted ---- HCA 806
New training manual ---- RWL 24
Nurses, use of, emphasized ---- HCA 808
Nursing homes versus day care, costs compared ---- HCA 749
Outpatient placement difficult ---- HCA 545
Oversedation: Path of least resistance ---- HCA 756
Physicians unprepared ---- HCA 738
Preventive care important ---- HCA 745
Problems classified ---- NRE 646
Program coordination needed ---- HCA 529
Proprietary agencies, licensing difficulties ---- HCA 652
Reasonable costs possible ---- HCA 807
Rural doctors declining ---- HCA 562
Screening units needed ---- NRE 644
Services, definitions vary ---- NRE 704
Standards, adherence to ---- HCA 805
Standards enforcement discussed ---- HCA 797
State limitations cited ---- HCA 811
Support system critical ---- HCA 802
Telephone reassurance, importance of ---- HCA 549
Title XX expenditures listed ---- HCA 814
Transportation: A continuing problem ---- HCA 804
Unanswered question ---- HCA 657
"Warehousing" in nursing homes ---- HCA 493
Health, Education, and Welfare, Department of: ---- HCA 637
Beal, Frank S., Health Care Financing Administration, statement ---- MAP 3
Califano, Hon. Joseph A., Secretary, statement ---- RWL 6
Derzon, Robert, Administrator, Health Care Financing Administration, statement
Health care: ---- HCA 491
Program timetable promised
Research ---- HCA 498
Studies ---- HCA 489
Unanswered question ---- HCA 487
Lashof, Dr. Joyce C., Deputy Assistant Secretary for Health Programs, statement ---- HCA 493
Long-term care: ---- HCA 484
Administrative focal point questioned
Timetable ---- HCA 494
Nicholson, Donald, Office of Program Integrity, statement ---- HCA 759
Ruff, Charles F. C., Deputy Inspector General, statement ---- MAP 3
Suzuki, Michael, Office of Human Development Services, statement ---- MAP 8
Health insurance: ---- HCA 803
Advertising techniques, illustrations
Agents: ---- MGI 21
Company responsibility
Termination of policies ---- MGI 271
Unlicensed ---- MGI 88
Companies: ---- MGI 222
Policy cited
Practices questioned case history ---- MGI 66
Standards exceeded ---- MGI 31
---- MGI 68

NOTE: See page 221 for guide to code abbreviations

Page

- Health insurance—Continued
  - "Company-switching" practices MGI 224
  - Counseling services necessary MGI 249
  - Duplications of coverage MGI 92
  - Federal involvement necessary MGI 236
  - Federal versus State regulation MGI 261
  - Fraud:
    - Prevalence questioned MGI 272
    - Tougher sentences needed MGI 230
    - Witnesses, difficulty in obtaining MGI 233
  - Fraudulent solicitations, examples MGI 219, 263
  - "Goose list," examples MGI 227
  - Misrepresentation MGI 93
  - New provisions initiated MGI 50
  - New State requirements MGI 78
  - Overselling of policies MGI 72
  - Policy duplications MGI 237
  - Policy standardization sought MGI 90
  - "Preexisting condition" clauses, abuse of MGI 238
  - Problems in buying, news articles MGI 5
  - Sales practices, unethical MGI 216
  - Self-policing of companies MGI 244
  - Texas mail fraud investigation MGI 215
  - Total coverage nonexistent MGI 76
  - Underwriting, unethical practices MGI 77
- Health Insurance Institute, Washington, D.C., publication MGI 167
- Heffernan, Helen R., Tallahassee, Fla., statements HCA 763, NRE 1382
- Henderson, Dr. Ed, Florida Retired Teachers Association/Association of Retired Persons, statement HCA 749
- Henle, Peter, Deputy Assistant Secretary, Department of Labor, statement RWL 112
- Hermanova, Dr. Hana, scientific secretary, Third Medical Clinic, Prague, Czechoslovakia, statement GON 21
- Hermelin, William M., American Health Care Association, Washington, D.C., letter MAP 47
- Hill, Ann D., director, St. Martin de Porres Multiservice Senior Center, Providence, R.I., statement SCA 20
- Hillenbrand, Bernard F., executive director, National Association of Counties, Washington, D.C., letter SCA 66
- Hollander, Prof. Carel F., Director, Institute for Experimental Gerontology TNO, Rijswijk, Netherlands:
  - Letter GON 66
  - Statement GON 30
- Hollopeter, Herschel and Hilda, Terre Haute, Ind., letter NRE 826
- Holloway, Grace, nutrition program for seniors, Yarnell, Ariz., statement NRE 669
- Holyoke-Chicopee (Mass.):
  - Home Care Corp., statement of Mary Forrester, board of directors HCA 654
  - Regional Home Care Corp., Inc., statement of William Rabbitt, executive director HCA 651
- Holyoke, Mass.:
  - Geriatric Authority, statement of Joseph Paul HCA 643
  - Visiting Nurses Association, Inc., statement of Sarah Cody, executive director HCA 674
- Home care:
  - National study undertaken HCA 673
  - Unmet needs HCA 672
- Homemakers-Upjohn Co., Washington, D.C., statement of Ronald E. Rosenberg, vice president HCA 801
- Hopi Tribal Bureau on Aging, Oraibi, Ariz., statement of Alexander W. Ami, director NRE 856
- Hopper, Genevieve, White Mountain Apache Tribe, Whiteriver, Ariz., statement NRE 865
- Hord, Rev. Noel E., Vigo County (Ind.) community action program, statement NRE 805

NOTE: See page 221 for guide to code abbreviations.

Page

- Horning, Jack, director, Illinois green thumb program, Springfield, Ill., statement — NRE 1440
- Houghton, Ruth R., Maricopa County Community Services, Phoenix, Ariz., paper — NRE 749
- Housing:
  - Budget funding levels — PFB 7
  - Deterioration: elderly first victims — HCA 679
  - Federal housing assistance plan — SRO 25
  - Goals and patterns — SRO 24
  - Housing and Community Development Amendments — AAL 7
  - Objective: Independent living — HCA 680
  - Rent subsidies, importance of — HCA 678
  - Supportive services necessary — SRO 31
  - Urban renewal, problems caused by — SRO 4
- Housing and Community Development Amendments — AAL 7
- Howard, Phyllis C., president, Area IX Council on Aging, Connersville, Ind., letter — NRE 817
- Hubb, Dr. Lewis, Massachusettes Department of Mental Health, statement — HCA 682
- Hudson, Joseph B., director, Area Telecare Service, Inc., Gibson City, Ill., letter — NRE 1458
- Hymel, Stella, Pensacola, Fla., statement — NRE 1273
- Hynes, Charles J., New York State deputy attorney general, statement — MAP 22

I

- Illinois Department on Aging:
  - Klage, Richard E., consultant, Division of Field Services — NRE 1392
  - Oblinger, Josephine, director — NRE 1389
- Indian Commission on the Aging and Aged, Indianapolis, Ind., statement of Maurice Endwright, executive director — NRE 765
- Indiana Advisory Council on Aging, statement of Louise Johnson, vice president — NRE 789
- Indiana Commission on the Aging and Aged, Indianapolis, Ind., statement of Sidney Levin, chairman — NRE 768
- Indiana Senior Citizens Association, statement of Martin Miller, president — NRE 808
- Inkster, Dr. Douglas E., director, New York Infirmary Center for Independent Living, New York City, statement — VIA 21
- Internal Revenue Service:
  - Agents, rehiring of former — TFE 20
  - Elderly, efforts to aid — TFE 10
  - Kurtz, Jerome, Commissioner, statement — TFE 9
  - Tax assistance to elderly — TFE 23
  - Tax bracket "notches" questioned — TFE 15
  - Tax counseling assistance, reimbursement for — TFE 19
  - Tax cut, economic stimulus questioned — TFE 17
  - Tax forms, simplification of — TFE 11
  - Tax information, accuracy of — TFE 13
  - Taxes, counselors, use of — TFE 40, 50
  - Taxpayer assistance — TFE 9
  - Toll-free telephone assistance — TFE 9

J

- Jacks, Margaret H., Florida Council on Aging, Tallahassee, Fla., statement — HCA 742
- Jansen, John, president, Mohave County, Ariz., Council on Aging, statement — NRE 684
- Japan, Tokyo, statement of Dr. Kunio Oota, Metropolitan Institute of Gerontology — GON 31
- Johnson, Louise, vice president, State Advisory Council on Aging, Greencastle, Ind., statement — NRE 789
- Joshua, J. L., Gainesville, Fla., outreach coordinator, statement — NRE 1366
- Judd, Abia W., Prescott, Ariz., statement — NRE 663

NOTE: See page 221 for guide to code abbreviations.

K

Page

Kane, Billy, director, Native American program, White Mountain Apache Tribe, Whiteriver, Ariz., statement .... NRE 860
Kaskowitz, Ed, executive director, Gerontology Society, statement .... RWL 317
Keck, Martha A., social and economic services, Inverness, Fla., statement .... NRE 1360
Kelson, Kenneth, board of commissioners, Escambia County, Fla., statement .... NRE 1263
Kennedy, Senator Edward M., statement .... HCA 635
Kerr, Ellen, Tallahassee, Fla., statement .... HCA 761
Kinnel, Mayor Harry, Albuquerque, N. Mex., statement .... NRE 1141
Klage, Richard E. consultant, division of field services, Illinois Department on Aging, Springfield, Ill., statement .... NRE 1392
Klowden, Jules L., insurance counselor, Senior Citizens Service Center, San Diego, Calif., statement .... MGI 46
Knight, Grace, Gainesville, Fla., statement .... NRE 1356
Knight, Sidney, Gainesville, Fla., statement .... NRE 1368
Knowles, Catherine Steinhauser, president, Arizona Council of Senior Citizens, statement .... NRE 694
Knowles, Charles, president, Council of Senior Citizens Organization of Pima County, Ariz., statement .... NRE 735
Kofoot, Beverly A., supervisor, Ford County homemaker program, Paxton, Ill., statement .... NRE 1426
Kohrt, Gladys, administrator, Livingston County Public Health Department, Pontiac, Ill., statement .... NRE 1428
Krieger, Paul secretary, North Central Florida Coalition of Senior Citizens, statement .... NRE 1330
Kuffer, Jack, Palo Duro Senior Center, Northeast Heights, N. Mex., statement .... NRE 1182
Kurtz, Jerome, Commissioner, Internal Revenue Service, statement .... TFE 9

L

Labor, Department of:
  Henle, Peter, Deputy Assistant Secretary, statement .... RWL 112
  Marshall, Hon. F. Ray, Secretary, statement .... RWL 112
Lacayo, Carmela G., executive director, Association Nacional Pro Personas Mayores statement .... RWL 291
Lane, Neal E., director, Delaware County, N.Y., Office for the Aging, statement .... NRE 1377
Lashof, Dr. Joyce C., Deputy Assistant Secretary for Health Programs, HEW, statement .... HCA 484
Laudeman, Dallyn, president, Cochise County Council on Aging, Wilcox, Ariz., statement .... NRE. 720, 735
Leavitt, Dr. Milo, Director, Fogarty International Center, HEW, statement .... GON 37
Leffler, Elias A., supervisor, Florida Green Thumb program, Jacksonville, Fla., statement .... NRE 1345
Legal Services Corporation, proposed increase .... PEB 10
Leisk, Mary Fran, Cottonwood, Ariz., statement .... NRE 667
Lepard, Katheryn, director, Hospitality House, Roswell, N. Mex., statement .... NRE 917
Levin, Sidney, chairman, Indiana Commission on the Aging and Aged, Indianapolis, Ind., statement .... NRE 768
Lewis, John, executive director, Intertribal Council of Arizona, statement .... NRE 846
Lexington-Fayette County, Ky., Health Department, statement of Dr. Philip G. Weiler, commissioner .... HCA 529
Libow, Dr. Leslie S., associate professor of medicine, New York State University:
  Letter .... HCA 613
  Paper .... HCA 614
Lifelong Learning Act, outline and goals .... RWL 278

NOTE: See page 221 for guide to code abbreviations.

Page

Lindsay, Sharon, director, Champaign County Office on Aging, Urbana, Ill., statement .... NRE 1403
Lipscomb, E. Bentley, program staff director, Florida Office on Aging and Adult Services, Tallahassee, Fla., statements .... HCA 713, SCA 4
Livingston, K. E., vice president, Retired Housing Corp., Portales, N. Mex., statement .... NRE 931
Llinas, Joseph J., executive director, North Central Florida Community Mental Health Center, Gainesville, Fla., statement .... NRE 1381
Long-term care, administrative focal point questioned .... HCA 494
Lopez, Erma, manager, food programs, Six Sandoval Indian Pueblos, Inc., N. Mex., statement .... NRE 1129
Lovato, Remijio, Santa Fe, N. Mex., Advisory Board, statement .... NRE 1038
Lovejoy, Ruth, executive director, Okaloosa County, Fla., Council on Aging, statement .... NRE 1267
Lowry, Robert E.:
  Correspondence .... MGI 96
  Statements .... MGI 30, 95
Lucero, Osmundo, chairman, AAA Advisory Board, Santa Fe, N. Mex., statement .... NRE 997
Lujan, Vincent, programs director, Taos Pueblo Cap, N. Mex., statement .... NRE 1033
Lundberg, David A., director, Navajo Aging Services, Window Rock, Ariz.:
  Resolutions .... NRE 890
  Statements .... NRE 850, 1200
Lupu, Marian, director, Pima Council on Aging, Tucson, Ariz., statement .... NRE 695
Lyon, Juana P., executive director, National Indian Council on Aging, Inc., Albuquerque, N. Mex.:
  Letter .... SCA 62
  Statement .... NRE 1236

M

Mack, Robert W., administrator, St. Camillus Health and Rehabilitation Center, Syracuse, N.Y., letter .... HCA 590
Mahoney, Jeanne, Pinal-Gila Council for Senior Citizens, Florence, Ariz., statement .... NRE 711
Mann, Joseph B., Arizona State University, papers .... NRE 742
Manning, Frank J., executive director, Massachusetts Association of Older Americans, Inc., statement .... HCA 666
Marks, Bernard R., JYC Neighborhood Center, Philadelphia, Pa., letter .... SCA 57
Marlin, David H., National Council of Senior Citizens, statement .... TFE 22
Marshall, Hon. F. Ray, Secretary, Department of Labor:
  Letter .... RWL 154
  Statement .... RWL 112
Martinez, Alice, statement .... NRE 978
Martinez, J. B., Taos, N. Mex., statement .... NRE 1015
Martinez, Lee, program director, Administration for Native Americans, Jicarilla Apache Tribe, N. Mex., statement .... NRE 1017
Massachusetts Association of Older Americans, Inc., statement of Frank J. Manning, executive director .... HCA 666
Massachusetts Department of Elder Affairs, statement of Dr. James J. Callahan, Jr., secretary .... HCA 660
Massachusetts Department of Mental Health, statement of Dr. Lewis Hubb .... HCA 682
Matter, Charles, Senior Citizens Center, Cerrillos, N. Mex., statement .... NRE 1049
Matthews, Henry, Champaign, Ill., statement .... NRE 1436
McClelland, John F., president, National Association of Retired Federal Employees, statement .... RWL 355
McGuire, Kay, Paxton, Ill., statement .... NRE 1433
McKinley, Howard, Sr., vice president, Navajo Nation Aging Council, Arizona:
  Resolutions .... NRE 1230
  Statements .... NRE 874, 1209

NOTE: See page 221 for guide to code abbreviations.

Page

- Medicaid:
  - Antifraud programs, recommendations ..... MAP 4
  - Duplications of coverage ..... MGI 92
  - Fraud control units:
    - Establishment of, recommendations ..... MAP 4
    - State incentives necessary ..... MAP 13
  - Fraud investigation:
    - Chain operations cited ..... MAP 34
    - Cost-benefits ratio cited ..... MAP 17
    - Departmental cooperation necessary ..... MAP 21
    - Leniency of courts ..... MAP 16
    - Recovery of funds ..... MAP 23
    - Successes minimal ..... MAP 12
  - Reimbursement gaps ..... HCA 725
- Medicaid mills, ownership, difficulty in determining ..... MAP 18
- Medicare:
  - Antifraud programs, recommendations ..... MAP 4
  - Counseling services necessary ..... MGI 249
  - Coverage gaps ..... MGI 246
  - Fraud control units, establishment of recommendations ..... MAP 4
  - Home dialysis encouraged ..... PFB 4
  - Hospital insurance, table ..... PFB 5
  - Reimbursement timelag ..... NRE 954
  - Supplementary medical insurance, table ..... PFB 5
- Medicare-Medicaid Anti-Fraud and Abuse Amendments ..... AAL 5
- Mendez, Guadalupe, Southeastern New Mexico Area Agency on Aging, Roswell, N. Mex., statement ..... NRE 913
- Mental health, programs limited ..... HCA 672
- Merin, Charles L., legislative representative, National Association of Retired Federal Employees, statement ..... RWL 293
- Miga, Felix, Pensacola, Fla., statement ..... NRE 1278
- Mike, Joseph C., Connecticut State Insurance Commissioner, statement ..... MGI 245
- Miller, Rev. George L., Pensacola, Fla., statement ..... NRE 1277
- Miller, Martin, president, Indiana Senior Citizens Association, statement ..... NRE 808
- Mines, Irma, executive director, vocations and Senior Centers Association, Inc., New York City, letter ..... SCA 58
- Montoya, Elizabeth, Senior Citizens Center, Winslow, Ariz., statement ..... NRE 675
- Montoya, Ron, executive director, Mayor's Office for Senior Citizens, Albuquerque, N. Mex., statement ..... NRE 1171
- Moore, Florence, executive director, National Council for Homemaker-Home Health Aide Services, Inc.:
  - Letters ..... HCA 825, 879
  - Testimony ..... HCA 808
- Moore, Tom, On Lok Senior Health Services, San Francisco, Calif., statement ..... HCA 572
- Morrison, Verne B., Escambia County Senior Citizens Committee, Pensacola, Fla., statement ..... NRE 1251
- Morrow, Owen L., administrator, Lakeview Christian Nursing Home, Carlsbad, N. Mex.:
  - Letter ..... NRE 986
  - Statement ..... NRE 942
- Mullen, Thelma, Pinal-Gila Council for Senior Citizens, Arizona, statement ..... NRE 722
- Murray, Jewel, director, Columbia County Council on Aging, Lake City, Fla., statement ..... NRE 1323
- Myers, John T., a U.S. Representative from Indiana, statement ..... NRE 768

N

- National Association of Area Agencies on Aging, statement of Wallace Clair ..... SCA 11

NOTE: See page 221 for guide to code abbreviations.

Page

- National Association of Home Health Agencies, St. Louis, Mo., testimony of John Byrne, president .... HCA 808
- National Association of Retired Federal Employees:
  - Merin, Charles L., legislative representative, statement .... RWL 293
  - Skardon, Stephen, legislative assistant, statement .... TFE 42
- National Association of Retired Federal Employees, statement .... RWL 358
- National Association of Social Workers, policy on aging .... NRE 1447
- National Association of State Units on Aging, recommendations of .... SCA 54
- National Caucus on the Black Aged, Inc., statement of Dolores Davis, executive director .... RWL 306
- National Council for Homemaker-Home Health Aide Services, Inc., testimony of Florence Moore, executive director .... HCA 789
- National Council of Senior Citizens:
  - Amyx, Eugene R., chairman, Central Florida Chapter, statement .... HCA 750
  - Danstedt, Rudolph T., statement .... RWL 279
  - Marlin, David H., director, legal research and services for the elderly .... TFE 22
- National Council of State Public Welfare Administrators, Hartford, Conn., statement of Stephen H. Press .... MAP 28
- National Council on the Aging, Inc.:
  - Ahrens, Robert J., statement .... RWL 221
  - Elderly employment, recommendations .... RWL 235
  - Employment survey results .... RWL 224
  - National Association of Older Worker Employment Services .... RWL 223
  - Retirement planning program .... RWL 222
  - Senior Community Service Project .... RWL 222
- National Gray Panthers, Washington, D.C., statement of Dr. Bernard I. Forman, representative .... RWL 288
- National Energy Act .... AAL 4
- National Health Service Act, a holistic approach .... RWL 289
- National Indian Council on Aging:
  - Blakely, Anne E., liaison assistant, statement .... RWL 321
  - Stevens, Jess J., statement .... NRE 868
- National Institute on Aging:
  - Articles:
    - Educational Gerontology .... GON 80
    - Journal of the American Geriatrics Society .... GON 73
    - Public Health Reports, HEW .... GON 82
  - Butler, Dr. Robert, Director, statement .... GON 10
  - Meeting notes of directors of national institutes .... GON 72
  - Research plan on aging .... GON 91
- National Institute of Senior Centers, statement of Leona M. Woolf .... SCA 14
- National Institutes of Health, Fogarty International Center fellowship programs .... GON 89
- National League for Nursing, New York City, statement of Joan E. Caserta, director, division of home health agencies and community health services .... HCA 791
- National Retired Teachers Association/American Association of Retired Persons:
  - Brickfield, Cyril F., executive director, statement .... RWL 236
  - Reports .... RWL 335, 337, 340
  - Stanat, Arthur, tax aide counselor, statement .... TFE 39
- Native American Senior Citizen Program of Phoenix, Ariz., statement .... NRE 896
- Navajo Aging Services, Window Rock, Ariz., statement of Davis A. Lundberg, director .... NRE 850
- Navajo Council on Aging:
  - McKinley, Howard, statement .... NRE 874
  - Singer, Amos F., statement .... NRE 877
  - Stewart, Irene, statement .... NRE 882
- Nees, Elizabeth E., letter .... NRE 815
- Netherlands, Rijswijk, statement of Prof. Carel Hollander, Director, Institute for Experimental Gerontology TNO .... GNO 81

NOTE: See page 221 for guide to code abbreviations.

Page

New England Nonprofit Housing Development Corp., Concord, N.H., statement of Morton Blumenthal, executive director HCA 682
New Mexico Department of Insurance, statement of Manuel A. Garcia, Jr., superintendent MGI 262
New York Infirmary Center for Independent Living, New York City, statement of Dr. Douglas E. Inkster, director VIA 21
Nicholson, Donald, Office of Program Integrity, HEW, testimony MAP 15
Norman, Sam, Lovington, N. Mex., statement NRE 963
Norris, Alice, director, Papago Wise Ones Program, Sells, Ariz., statement NRE 848
Norway, Oslo, statement of Dr. Gudmund Harlem, Medical Director, Institute of Medical Rehabilitation GON 24
Nursing homes:
  Abuses, news articles RWL 39
  Budget funding levels PFB 8
  Disproportionate costs RWL 23
  Medicaid reimbursement gaps HCA 725
  Medicare patients excluded HCA 751
Nutrition:
  Emergency care, importance of HCA 668
  Facilities not fully utilized HCA 727
  Program expansion AAL 10

O

Oblinger, Josephine, director, Illinois Department of Aging, Sherman, Ill., statement NRE 1389
O'Hare, John J., LeRoy, Ill., statement NRE 1431
Older Americans Act:
  Changes suggested SCA 19
  Data:
    Accountability for POA 5
    Usefulness questioned POA 5
  Funding, tables AAL 20
  Goals cited SCA 16
  Nutrition, program expansion AAL 10
  Paperwork:
    Document analysis POA 50
    Key issues POA 33
    Tables POA 36
    Volume of, statistics POA 2
  Proposed funding, table PFB 3
  Recent legislation AAL 8
  Recommended changes NRE 909
  Senior centers, funding of SCA 5
Olsen, Mary, president, Chaves County (N. Mex.) Retired Teachers Association, statement NRE 930
On Lok Senior Health Services, San Francisco, Calif.:
  Ansak, Marie-Louise, statement HCA 561
  Funding sources needed HCA 562
  Gee, Dr. William, statement HCA 571
  Moore, Tom, statement HCA 572
Oota, Dr. Kunio, Director, Metropolitan Institute of Gerontology, Tokyo, Japan, statement GON 31
Osborne, Ed, president, New Mexico Pharmaceutical Association, Roswell, N. Mex., statement NRE 946
Osterbind, Carter C., director, center for gerontological studies and programs, University of Florida, Gainesville, Fla., letter NRE 1373
Owen, George, chairman, Mayor's Commission on Aging, Roswell, N. Mex.:
  Letter NRE 977
  Statement NRE 921

P

Pacific Medical Center's Low Vision Service, San Francisco, Calif., statement of August Colenbrander, M.D., medical director VIA 5

NOTE: See page 221 for guide to code abbreviations

Page

Paperwork:
  Aging network, problems of — POA 23
  Compliance documents — POA 26
  Document analysis — POA 50
  Issuance system — POA 27
  Key issues — POA 33
  Standards of performance reports — POA 57
  Tables — POA 36
  Volume of, statistics — POA 2
Parker, Nate, director, Albuquerque, N. Mex., Urban Indian Center, statement — NRE 1187
Parrish, Eva M., Pensacola, Fla., letter — NRE 1306
Parry, Madeline, director, Commission on Aging, Artesia, N. Mex., statement — NRE 960
Paul, Joseph, executive director, Holyoke, Mass., Geriatric Authority:
  Reports — HCA 685
  Statement — HCA 643
Paytiamo, Stanley, governor, Pueblo de Acoma, Acomita, N. Mex., statement — NRE 1122
Pebworth, Jo, specialist, center for public representation, Madison, Wis., statement — MGI 162
Percy, Senator Charles H., statements — NRE 763, 1387, RWL 54, 118
Perregaux, Edmond A., Jr., 222 project director, Providence, R.I., statement excerpts — HCA 596
Pierson, Homer, chairman, Torrance County, N. Mex., Advisory Board:
  News articles — NRE 1220
  Statement — NRE 1107
Pinkerton, Phyllis, director, East Central Illinois Area Agency on Aging, Bloomington, Ill., statement — NRE 1396
Pohle, Mark, Ajo, Ariz., statement — NRE 718
Poole, Barbara H., Chaves County Health Department Field Office, Roswell, N. Mex., statement — NRE 936
Poverty level, persons below, table — RWL 258
Powell, Dorothy, Pinal County (Ariz.) Community College, statement — NRE 737
Presley, Vera, Pensacola, Fla., regional supervisor, Escambia County Homemaker Service, statement — NRE 1257
Press, Stephen H., National Council of State Public Welfare Administrators, Hartford, Conn:
  Letter — MAP 46
  Statement — MAP 28

Q

Quinn, Joan, executive director, Project Triage, Inc., Plainville, Conn., statement — HCA 499

R

Rabbitt, William, executive director, Holyoke-Chicopee (Mass.) Regional Home Care Corp., Inc.:
  Case studies — HCA 697
  Statement — HCA 651
Rael, J. B., Questa, N. Mex., statement — NRE 1005
Railroad retirement annuities, statistics — PFB 12
Ramsey, Una, Whittman, Ariz., statement — NRE 730
Randolph, Senator Jennings, statement — VIA 15
Rayburn, Rosita, Expanola, N. Mex., statement — NRE 1011
Reecer, Larry M., managing attorney, senior citizens law office, Albuquerque, N. Mex., statement — NRE 1145
Reid, Olivia G., project director, Joy Center, Hagerman, N. Mex., statement — NRE 965
Reilly, Donald F., Deputy Commissioner, Administration on Aging, statement — SCA 7
Retina Foundation, Eye Research Institute, Boston, Mass., articles — VIA 58
Retired Senior Volunteer program, Chicopee, Mass.:
  Budget lowers funding — PFB 8
  Statement of Dane B. Wheeler, executive director — HCA 680

NOTE: See page 221 for guide to code abbreviations.

Page

- Retirement:
  - Civil service, recent legislation ... AAL 1
  - Cost-of-living adjustment ... RWL 143
  - Counseling needed ... RWL 181, 295
  - Deferral incentives suggested ... RWL 12
  - "Double-dipping" cited ... RWL 182
  - Effect on elderly ... GON 47
  - Elimination of mandatory ... RWL 178
  - Federal incentives for early ... RWL 179
  - Flexitime program ... RWL 34, 228
  - Incentives to defer ... RWL 59, 139
  - Inflation:
    - Apprehension evident ... RWL 226
    - Effect of ... RWL 136, 189
    - Impact ... RWL 36
  - Job "downgrading" considered ... RWL 196
  - Longevity increase, effect of ... RWL 188
  - Mandatory, opposition to ... RWL 313
  - National pension system ... RWL 246
  - Part-time employment encouraged ... RWL 116
  - Pension plans:
    - Funding responsibility ... RWL 193
    - Inequities cited ... RWL 191
    - Integration of ... RWL 17
    - Mismanagement ... RWL 117
    - "Piggy-backing" with social security ... RWL 140
    - Private, value of ... RWL 37
    - Underfunding ... RWL 8
  - Recent trends ... RWL 11, 113
  - "The golden bridge" plan ... RWL 230
  - Trend toward early ... RWL 33
  - Women, decreased benefits ... RWL 254
- Reynolds, Dr. Richard C., chairman, Department of Community Health and Family Medicine, University of Florida, Gainesville, Fla., statement ... NRE 1312
- Rigby, J. Lester, director, Southern Rio Grande Area Agency on Aging, Socorro, N. Mex., statement ... NRE 1175
- Riker, Prof. Harold C., counselor, Education Department, University of Florida, Gainesville, Fla., statement ... NRE 1304
- Rinaldi, Ophelia, project director, elderly services, Sandoval County, N. Mex., statement ... NRE 1111
- Rish, William J., Florida State representative:
  - Letter ... HCA 765
  - Statement ... HCA 718
- Rivera, Gilberto R., chairman, Chaves County Pharmaceutical Board, Roswell, N. Mex., statement ... NRE 950
- Roache, Catharine S., Albuquerque, N. Mex., statement ... NRE 1213
- Roberts, Hollace, Green Valley, Ariz., statement ... NRE 724
- Robinson, Ken, chairman, Older Americans Advisory Council, Council of Governments, Albuquerque, N. Mex., statement ... NRE 1163
- Romancito, Mark J., Zuni Tribal Social Service, Zuni, N. Mex., statement ... NRE 1233
- Romania, Bucharest, statement of Prof. Ana Aslan, Director, National Institute of Gerontology and Geriatrics ... GON 17
- Rosenberg, Ronald E., vice president, Homemakers-Upjohn Co., Washington, D.C., statement ... HCA 801
- Ross, Thomas A., director, Region XI Area Agency on Aging, Columbus, Ind., statement ... NRE 826
- Ruff, Charles F. C., Deputy Inspector General, HEW:
  - Letter ... MAP 43
  - Statement ... MAP 8
- Runnels, Hope, executive director, Visiting Nurse Association, Portland, Oreg., statement ... HCA 796
- Ruskin, William, Holbrook, Ariz., statement ... NRE 885
- Ryan, Richard, Mattoon, Ill., statement ... NRE 1440

NOTE: See page 221 for guide to code abbreviations.

S

Page

Sanchez, Ernestina, chairman, Eastern Valencia County, N. Mex., Advisory Board, statement ... NRE 1115
San Francisco, Calif., Home Health Service, statements of Hadley Hall, executive director ... HCA 572, 789
Santillanes, David M., chairman, Bernalillo County (N. Mex.) Commission, letter ... NRE 1232
Sapien, Claudio, Eddy County (N. Mex.) Community Action Senior Citizens nutritional program, statement ... NRE 980
Schmidt, Winsor, Florida State Hospital, Chattahoochee, Fla., statement ... HCA 752
Schloss, Irvin P., American Foundation for the Blind, Inc., Washington, D.C., statement ... VIA 47
Schroeder, Ray, Dwight, Ill., statement ... NRE 1433
Scotland, Glasgow:
  Elderly services described ... GON 15
  Statement of Sir Ferguson Anderson, University of Glasgow ... GON 14
Seltzer, Dr. Mildred M., president, Association for Gerontology in Higher Education, statement ... RWL 296
Sena, John "Bouncer", commissioner, Santa Fe County, N. Mex., letter ... NRE 1242
Sena, Pete, Ojo Caliente, N. Mex., statement ... NRE 1013
Senior centers:
  Accreditation discussed ... SCA 37
  Area funding ... SCA 13
  Background information ... SCA 41
  Definition of ... SCA 7
  Funding, block grants ... SCA 33
  Funding of ... SCA 5
  Growth noted ... SCA 8
  Importance of ... SCA 4
  Physicians donate time ... SCA 24
  Recommendations listed ... SCA 5
  Services offered by ... SCA 15
  Surveys conducted ... SCA 30
Senior Citizens Service Center, San Diego, Calif., statement of Jules L. Klowden, insurance counselor ... MGI 46
Serasio, Elmer, El Mirage, Ariz., statement ... NRE 734
Shelden, George H., Florida State representative:
  Letter ... HCA 766
  Report of subcommittee ... HCA 767
Shepard, Josephine A., mayor, Jemez Springs, N. Mex., letter ... NRE 1243
Sheppard, Dr. Harold L., American Institutes for Research, Washington, D.C.:
  Letter ... RWL 84
  Report excerpts ... RWL 87
  Statement ... RWL 54
Singer, Amos F., chairman, Navajo Council on Aging, Window Rock, Ariz., statement ... NRE 877
Single room occupancy:
  Articles:
    Commercial Appeal, Memphis, Tenn ... SRO 55
    Journal of Housing, Published by the National Association of Housing and Redevelopment Officials ... SRO 49
    Sunday Oregonian, Portland, Oreg ... SRO 56
  Berlin, Elaine, mayor's office on single room occupancy housing, New York City, conference excerpts ... SRO 13
  Bibliography: list of books and reports ... SRO 38
  Bohannan, Paul, Western Behavioral Sciences Institute, La Jolla, Calif., conference excerpts ... SRO 11
  Desirability of, reasons cited ... SRO 6
  Editorial and aritcles from the New York Post and New York Times ... SRO 43
  Ehrlich, Ira F., Institute of Applied Gerontology, St. Louis University, conference excerpts ... SRO 10

NOTE: See page 221 for guide to code abbreviations.

Single room occupancy—Continued — Page
  Ehrlich, Phyllis, paper — SRO 35
  Federal programs discourage — SRO 7
  Future discussed — SRO 22
  Golden, Sister Jean Patrice, senior citizens office, Calgary, Alberta, Canada, conference excerpts — SRO 14
  Improvements, financing of — SRO 29
  Jorgen, Robert, office of special housing services, New York City, conference excerpts — SRO 13
  Lifestyle, preservation of — SRO 8
  Limited community response — SRO 3
  Outreach services, mandated — SRO 9
  Residents fearful, distrustful — SRO 8
  Silverberg, Shirley, Roosevelt Hospital, New York City, conference excerpts — SRO 14
  Spohn, Roberta, Department for the Aging, New York City, conference excerpts — SRO 18
Sisneros, Severiano, Albuquerque, N. Mex., statement — NRE 1192
Sixkiller, Tammy, Native American senior Citizens program, Phoenix, Ariz., statement — NRE 881
Skardon, Stephen, legislative assistant, National Association of Retired Federal Employees, Washington, D.C., statement — TFE 42
Smedsrud, Milt, president, Communicating for Agriculture, Fergus Falls, Minn., statement — MGI 319
Smith, Bessie, representative of the elderly, Navajo Nation, statement — NRE 1205
Smith, Mamie, Champaign, Ill., statement — NRE 1435
Smith, Sophie, Governor's Advisory Committee on Aging, Florence, Ariz., statement — NRE 721
Smith, Susie E., Crystal River, Fla., statement — NRE 1360
Social security:
  Adjustment projected — PFB 3
  Consumer price index for elderly suggested — RWL 257
  Earnings limitation questioned — NRE 727
  Earnings test, elimination of — RWL 271
  Financial stability sought — TFE 53
  Financing:
    General revenues, limited use of — RWL 249
    Soundness of — RWL 281
    Use of general revenues — TFE 27, 51
  Funding, changes suggested — NRE 811
  Higher dependency ratio — RWL 264
  Public education lacking — RWL 63
  Recent legislation, statistics — AAL 12
  Retirement test, need for — RWL 282
  Tax exemption — RWL 18
  Termination of benefits, risks cited — RWL 251
Springfield, Mass., Housing Allowance Program, Inc., statement of Amy Anthony — HCA 677
Stanat, Arthur, tax aide counselor, NRTA/AARP, Washington, D.C., statement — TFE 39
Steg, Olaf W., president, Roswell, N. Mex., local, American Association of Retired Persons, statement — NRE 927
Stevens, Jess J., National Indian Council on Aging, San Carlos, Ariz., statement — NRE 868
Stewart, Irene, secretary, Navajo Council on Aging, Chinle, Ariz., statement — NRE 882
Strader, Michael, director, peace meal senior nutrition program, Charleston, Ill., statement — NRE 1413
Strand, Dr. Tim, White Mountain Apache Tribe, Whiteriver, Ariz., statement — NRE 865
Strickland, J. Hassler, district manager, Social Security Administration, Roswell, N. Mex., statement — NRE 953
Strobecker, William, chairman, Los Alamos County, N. Mex., Advisory Board, statement — NRE 1044

NOTE: See page 221 for guide to code abbreviations.

Page

Summers, Rev. A. C., Gainesville, Fla., statement .... NRE 1871

Sunley, Emil M., Deputy Assistant Secretary for Tax Policy, Department of the Treasury, statement .... TFE 3

Suzuki, Michael, Office of Human Development Services, HEW, statement .... HCA 803

Svanborg, Prof. Alvar, head, Clinic II Vasa Hospital, Gothenburg, Sweden, statement .... GON 34

Sweden, Gothenburg, statement of Prof. Alvar, Svanborg, head, Clinic II Vasa Hospital .... GON 34

T

Taos Pueblo Senior Citizens program, Taos, N. Mex., statement .... NRE 1077

Tassinari, Anita M., executive director, Alachua County Older Americans Council, Inc., Gainesville, Fla., statement .... NRE 1333

Taxes:
  - Administration proposals .... TFE 28
  - Assistance to elderly .... TFE 23
  - Bracket "notches" questioned .... TFE 15
  - Counseling assistance, reimbursement for .... TFE 19
  - Counselors, use of .... TFE 40
  - Energy Tax Act .... OIT 9
  - Forms, simplification questioned .... TFE 49
  - Information, accuracy of .... TFE 13
  - Itemized deductions, checklist of .... OIT 1
  - Means test criticized .... TFE 43
  - Relief cited for elderly .... TFE 3
  - Sick pay exclusion .... TFE 30
  - Simplification of forms .... TFE 11
  - Taxpayer assistance .... TFE 9
  - Tax Reduction and Simplification Act .... AAL 17
  - Toll-free telephone assistance .... TFE 9

Tenorio, Frank, secretary, All Indian Pueblo Council, New Mexico, statement .... NRE 1125

Texas Department of Human Resources, report on community care clients .... HCA 621

Thomas, John J., State representative, Brazil, Ind., statement .... NRE 793

Thomas, Dr. R. Glyn, European Office, World Health Organization:
  - Paper .... GON 71
  - Statement .... GON 36

Thompson, Sophie D., Public Health Service, HEW, letter .... SCA 67

Transportation:
  - Recent legislation .... AAL 19
  - Urban Mass Transportation Administration, grants by .... PFB 11

Treasury, Department of, statement of Emil M. Sunley, Deputy Assistant Secretary for Tax Policy .... TFE 3

Triage, Inc., Plainville, Conn.:
  - Doherty, Dr. Neville, research director, statement .... HCA 504
  - Eligibility criteria .... HCA 502
  - Project goals .... HCA 499
  - Quinn, John, executive director, statement .... HCA 499
  - Services offered by .... HCA 556

Trujillo, Meliton M., Taos, N. Mex., statement .... NRE 1014

U

Udall, Representative Morris K., statement .... NRE 698

U.S.S.R., Kiev:
  - Institute of Gerontology, elderly research cited .... GON 20
  - Statement of Prof. Dmitri F. Chebotarev, Director Institute of Gerontology of the U.S.S.R. Academy of Medical Sciences .... GON 19

U.S. Conference of Mayors' Task Force on Aging, statement of Hon. Gabriel Cazares .... HCA 636

Urban Mass Transportation Administration, grants by .... PFB 11

NOTE: See page 221 for guide to code abbreviations.

V

Page

- Varela, Eugene A., AAA coordinator, Santa Fe, N. Mex., statement NRE 998
- Vera Institute's Easyride program, New York City, statement of Claire Haaga, Cooney HCA 552
- Vermillion, Jeanne, chairperson, Champaign County, Ill., Committee on Aging, statement NRE 1461
- Veterans' benefits:
  - Projections, table PFB 10
  - Recent legislation AAL 19
- Vicenti, Edward, statement NRE 1053
- Victor, Dolly, San Carlos Apache nutrition project, San Carlos, Ariz., statement NRE 880
- Vigil, William S., planning director, State Commission on Aging, Santa Fe, N. Mex., statement NRE 907
- Vinsant, Moezelle B., nursing director, Chaves and Lincoln Counties, N. Mex., home health agencies, statement NRE 934
- Visiting Nurse Association, Portland, Oreg., statement of Hope Runnels, executive director HCA 796
- Visual impairment:
  - Aids suggested VIA 10
  - Blindness, definitions vary VIA 5
  - Counseling needed VIA 39
  - Demonstrations conducted VIA 19
  - Eye diseases, descriptions of VIA 6
  - Followup programs needed VIA 23
  - Funding, critical issue VIA 31
  - Glaucoma, early detection critical VIA 44
  - Increasing, reasons for VIA 18
  - Library services underutilized VIA 32
  - Lions Club, aid given by VIA 42
  - Professional shortcomings noted VIA 43
  - Rehabilitation programs needed VIA 29
  - Research, advances cited VIA 41
  - Research, waste evident VIA 38
  - Statistics VIA 9
  - Success in treating, case history VIA 17

W

- Warren, Aline, senior community aide, Williston, Fla., statement NRE 1354
- Wedewer, Donald H., director, Florida Division of Blind Services, Tallahassee, Fla., statement VIA 29
- Weidner, Stanley, Chenoa, Ill., statement NRE 1435
- Weiler, Dr. Philip G., commissioner, Lexington-Fayette County Health Department, Kentucky, statement HCA 528
- Weller, Evelyn, Pensacola, Fla., statement NRE 1270
- Wells, Charles, director, Chaves County Retired Senior Volunteer program, Roswell, N. Mex.:
  - Letter NRE 977
  - Statement NRE 915
- Wheeler, Dane B., executive director, retired senior volunter program, Chicopee, Mass., statements HCA 690, 703
- Whitcomb, Stuart E., president, Hi Neighbor, Roswell, N. Mex.:
  - Letter NRE 985
  - Statement NRE 924
- White Elizabeth Ann, Ajo (Ariz.) Senior Center, statement NRE 716
- White, Kenneth, Navaho Foster Grandparent Program, Fort Defiance, Ariz.:
  - Letter NRE 889
  - Statement NRE 883
- Whiting, Clifford, chairman, New Mexico Commission on Aging, statement NRE 1091

NOTE: See page 221 for guide to code abbreviations.

Page

Whiting, Doris, manager, Retirement Services Division, Chamber of Commerce, Roswell, N. Mex.:
  Letter .... NRE 960
  Statement .... NRE 922
Wilde, Harold R., commissioner of insurance, State of Wisconsin:
  Booklet .... MGI 110
  Papers .... MGI 131
  Statement .... MGI 75
Williams, Neely E., Buckeye, Ariz., statement .... NRE 732
Withers, Dr. William, president, New York Teachers Pension Association, Inc., New York City, statement .... RWL 216
Woodard, Curtis L., U.S. postal inspector, Houston, Tex., statement .... MGI 214
Woolf, Leon M., National Institute of Senior Centers, statement .... SCA 14
World Assembly on Aging:
  Authorization of .... AAL 8
  Proposed .... GON 11
World Health Organization, statement of Dr. R. Glyn Thomas, European Office .... GON 37
Wright, Harold W., president, Indiana Farmers Union, letter .... NRE 820
Wyden, Ron, legal services developer, State of Oregon, paper .... MGI 195

Y Z

Youngstrom, C. O., Idaho Federation of National Association of Retired Federal Employees, letter .... TFE 55
Zimmerman, Bruce, executive director, Hamilton County (Ind.) Senior Citizens Services, Inc., letter .... NRE 815

NOTE: See page 221 for guide to code abbreviations.

APR 23 1979

96TH CONGRESS
1st Session

SENATE

Rept. 96-
55 Part 2

PART 2—APPENDIXES
DEVELOPMENTS IN AGING: 1978

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 375, MARCH 6, 1978, AND
S. RES. 376, MARCH 6, 1978

Resolutions Authorizing a Study of the Problems
of the Aged and Aging

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

CG013702

APRIL 5 (legislative day, FEBRUARY 22), 1979.—Ordered to be printed

---

U.S. GOVERNMENT PRINTING OFFICE
42-394 O WASHINGTON : 1979

SPECIAL COMMITTEE ON AGING[1]

LAWTON CHILES, Florida, *Chairman*

FRANK CHURCH, Idaho
JOHN GLENN, Ohio
JOHN MELCHER, Montana
DAVID PRYOR, Arkansas
BILL BRADLEY, New Jersey
QUENTIN N. BURDICK, North Dakota

PETE V. DOMENICI, New Mexico
CHARLES H. PERCY, Illinois
JOHN HEINZ, Pennsylvania
NANCY LANDON KASSEBAUM, Kansas
WILLIAM S. COHEN, Maine

E. BENTLEY LIPSCOMB, *Staff Director*
DAVID A. AFFELDT, *Chief Counsel*
DAVID A. RUST, *Minority Staff Director*

---

[1] Amendment No. 23 to S. Res. 4, Reorganization of the Senate Committee System, agreed to Feb. 1, 1977, established the Special Committee on Aging as a permanent, nonlegislative committee under the rules of the Senate. Membership was reduced from 23 to 14 for the 95th Congress and by attrition must begin the 96th Congress with no more than nine members. S. Res. 21, Jan. 23, 1979, increased the membership on the committee to 10. S. Res. 101, Mar. 13, 1979, increased the membership on the committee to 12.

LETTER OF TRANSMITTAL

U.S. Senate,
Special Committee on Aging,
Washington, D.C., April 5, 1979.

Hon. Walter F. Mondale,
President of the Senate,
Washington, D.C.

Dear Mr. President: Under authority of Senate Resolutions 375 and 376, agreed to March 6, 1978, I am submitting to you the annual report of the Senate Special Committee on Aging, Developments in Aging: 1978, Part 2.

Senate Resolution 4, the Committee Systems Reorganization Amendments of 1977, authorizes the Special Committee on Aging "to conduct a continuing study of any and all matters pertaining to problems and opportunities of older people, including, but not limited to, problems and opportunities of maintaining health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activity, of securing proper housing and, when necessary, of obtaining care and assistance." S. Res. 4 also requires that the results of these studies and recommendations be reported to the Senate annually.

Therefore, on behalf of the members of the committee and its staff, I am pleased to transmit this report to you.

Sincerely,

Lawton Chiles, *Chairman.*

CONTENTS

Page

Letter of transmittal III

Appendix 1.—Annual report of the Federal Council on the Aging 1

Appendix 2.—Reports from Federal departments and agencies:

- Item 1. Department of Agriculture 20
- Item 2. Department of Commerce 30
- Item 3. Department of Defense 34
- Item 4. Department of Energy 34
- Item 5. Department of Health, Education, and Welfare:
  - Administration on Aging 43
  - Food and Drug Administration 99
  - Health Care Financing Administration 102
  - Health Resources Administration 113
  - Health Services Administration 116
  - National Institute on Aging 121
  - National Institute of Arthritis, Metabolism, and Digestive Diseases 134
  - National Institute of Mental Health 137
  - Office of Education 139
  - Office of Human Development 148
  - Social Security Administration 149
- Item 6. Department of Housing and Urban Development 155
- Item 7. Department of the Interior 167
- Item 8. Department of Justice (Law Enforcement Assistance Administration) 168
- Item 9. Department of Labor 169
- Item 10. Department of Transportation 177
- Item 11. Department of the Treasury 182
- Item 12. ACTION 189
- Item 13. Civil Aeronautics Board 194
- Item 14. Commission on Civil Rights 195
- Item 15. Community Services Administration 197
- Item 16. Comptroller General of the United States 205
- Item 17. Environmental Protection Agency 209
- Item 18. Federal Communications Commission 21
- Item 19. Federal Trade Commission 215
- Item 20. National Academy of Sciences 218
- Item 21. National Endowment for the Arts 219
- Item 22. National Endowment for the Humanities 223
- Item 23. National Science Foundation 229
- Item 24. Office of Consumer Affairs 247
- Item 25. Office of Personnel Management 251
- Item 26. Pension Benefit Guaranty Corporation 257
- Item 27. Postal Service 258
- Item 28. Railroad Retirement Board 262
- Item 29. Small Business Administration 264
- Item 30. Veterans Administration 264

96th Congress } SENATE { Rept. 96–
1st Session } { 55 Part 2

PART 2—APPENDIXES

DEVELOPMENTS IN AGING: 1978

April 5 (legislative day, February 22), 1979.—Ordered to be printed

Mr. Chiles, from the Special Committee on Aging,
submitted the following

REPORT

APPENDIXES

Appendix 1

ANNUAL REPORT OF THE FEDERAL COUNCIL ON THE AGING

March 20, 1979.

Dear Mr. Chairman: I am very pleased to submit the 1978 Annual Report of the Federal Council on the Aging for inclusion in the "Developments in Aging" publication (1978).

As always, we appreciate having the opportunity to work with the U.S. Senate Special Committee on Aging on behalf of our Nation's elderly population.

The best of luck in 1979 with, as per usual, a heavy Senate Special Committee on Aging agenda.

Sincerely,

N. Alan Sheppard,
Special Assistant to the Chairman.

Enclosure.

PREFACE

Legislative Mandate

The Federal Council on the Aging was created by the Congress under provisions of the 1973 amendments to the Older Americans Act for the purpose of advisting the President, the Secretary of the Department of Health, Education, and Welfare, the Commissioner on Aging, and the Congress on matters relating to the special needs of older Americans.

On October 18, 1978, the President signed into law H.R. 12255 (Public Law 95–478), the Comprehensive Older Americans Act Amendments of 1978. The new legislation directs the Council, as was mandated in the 1973 Amendments to the Older Americans Act, to perform the following functions:

—Advise and assist the President on matters relating to the special needs of older Americans;

—Assist the Commissioner in making the appraisal of the Nation's existing and future personnel needs in the field of aging;

—Review and evaluate, on a continuing basis, Federal policies regarding the aging and programs and other activities affecting the aging conducted or assisted by all Federal departments and agencies for the purpose of appraising their value and their impact on the lives of older Americans;

—Serve as a spokesman on behalf of older Americans by making recommendations to the President, to the Secretary, the Commissioner, and the Congress with respect to Federal policies regarding the aging and federally conducted or assisted programs and other activities related to or affecting them;

—Inform the public about the problems and needs of the aging, in consultation with the National Information and Resource Clearinghouse for the Aging, by collecting and disseminating information, conducting or commissioning studies and publishing the results thereof, and by issuing publications and reports; and

—Provide public forums for discussing and publicizing the problems and needs of the aging and obtaining information relating thereto by conducting public hearings, and by conducting or sponsoring conferences, workshops, and other such meetings.

Changes in the Council as a Result of the 1978 Amendments

Older Americans Act of 1965, as Amended, 1973	Older Americans Act of 1965, as Amended, 1978
Section 205(a)	Section 205(a)
There is established a Federal Council on the Aging to be composed of fifteen members appointed by the President with the Advice and consent of the Senate for terms of three years without regard to the provisions of title 5 United States Code. Members shall be appointed so as to be representative of older Americans, national organizations with an interest in aging, business, labor and the general public. At least five of the members shall themselves be older persons.	amended: insert "rural and urban" after of in the second sentence. add: No full-time officer or employee of the Federal government may be appointed as a member of the Council.
	Section 205(c) delete: The Secretary and the Commissioner on Aging shall be ex-officio members of the Council.
Section 205(e) delete: The Secretary and the Commissioner shall make available to the Council such staff, information, and other assistance as it may require to carry out its activities.	Section 205(e) substitute: The Council shall have staff personnel, appointed by the Chairman, to assist it in carrying out its activities. The head of each Federal department and agency shall make available to the Council such information and other assistance as it may require to carry out its activities.

Changes in the Council as a Result of the 1978 Amendments--Continued

Section 205(g) delete:	Section 205(g) amended:
The Council shall undertake a study of the interrelationships of benefit programs for the elderly operated by Federal, State, and local government agencies. Following the completion of this study, but no later than January 1, 1976, the President shall submit to Congress recommendations for bringing about greater uniformity of eligibility standards, and for eliminating the negative impact that one program's standards may have on another.	The Council shall undertake a thorough evaluation and study of programs conducted under this Act. The study required in this subsection shall include: a) an examination of the fundamental purposes of such programs, and the effectiveness of such programs in attaining such purposes; b) an analysis of the means to identify accurately the elderly population in greatest need of such programs; and c) an analysis of numbers and incidence of low-income and minority participants in such programs. The study required under this subsection may include: a) an exploration of alternatives methods for allocating funds under such programs to States, State agencies on aging, and area agencies on aging in an equitable and efficient manner, which will accurately reflect current conditions and insure that such funds reach the areas of greatest current need and are effectively used for such areas; b) an analysis of the need for area agencies on aging to provide direct services within the planning and service area; and c) an analysis of the number of nonelderly handicapped in need of home delivered meal services.

Changes in the Council as a Result of the 1978 Amendments--Continued

Section 205(h)

delete:

The Council shall undertake a study of the combined impact of all taxes on the elderly - including but not limited to income, property, sales, social security taxes. Upon completion of this study, but no later than January 1, 1976, the President shall submit to Congress, and to the Governor and legislatures of the States, the results thereof and such recommendations as he deems necessary.

Section 205(i)

delete:

The Council shall undertake a study or studies concerning the effects of the formulae specified in section 303 for allotment among the States of sums appropriated for area planning and social service programs authorized under title III of this Act. Upon completion of this study, but no later than January 1, 1975, the results of such study, together with recommendations for such changes, if any, in such formulae as may be determined to be desirable and the justification for any changes recommended, shall be submitted to the Commissioner, the Secretary of Health, Education, and Welfare, the Committee on Labor and Public Welfare of the Senate and the Committee on Education and Labor of the House of Representatives.

Section 205(h)

amended:

There are authorized to be appropriated to carry out the provisions of this section, for fiscal years 1979, 1980, and 1981, such sums as may be necessary.

The changes, as noted above, affect the Council's autonomy, representation, and relationship with other Federal agencies. The hope of Council members is that the changes will indeed strengthen the Council's role and effectiveness on behalf of the Older Americans of this country.

PART 1. COUNCIL STRUCTURE AND OPERATION

There are several Federal laws affecting the operation of the Federal Council on the Aging. Of particular importance are the Older Americans Act and the Federal Advisory Committee Act. The Older Americans Act defines the Council's mission of advocacy for older Americans and certain specific operating procedures. The Federal Advisory Committee Act sets forth standards to insure the effective use of all advisory bodies within the Federal Government. Regular reports are filed with the committee management offices in the Office of Management and Budget and the Office of the Secretary, HEW As called for by the Older Americans Act, this calendar year report is compiled for the President. The FCA annual report also appears in "Developments in Aging" issued by the Senate Special Committee on Aging.

Council Membership

The Council is composed of 15 members nominated by the President and confirmed by the Senate. Eight members of the Council are themselves older persons. They and the other members are representative of the general public and national organizations with an interest in aging, from business, labor, urban and rural groupings required by law.

Since new Council members were not confirmed by the Senate until the year was practically half over, two Council rosters are listed.

Council Roster, January 1, 1978, to June 25, 1978

Chairman, Nelson H. Cruikshank; Vice Chairman, Garson Meyer.

MEMBERS

Bertha S. Adkins, of Oxford, Md.; former Chairman, Federal Council on the Aging; former Under Secretary of the Department of Health, Education, and Welfare.

Nelson H. Cruikshank, of the District of Columbia; Counselor to the President on Aging; former president, National Council of Senior Citizens; former director, department of social security, AFL-CIO.

Dorothy L. Devereux, of Honolulu, Hawaii; former member of the Hawaii State House of Representatives.

Charles J. Fahey, the Reverend Monsignor, of Syracuse, N.Y.; director of the Catholic Charities for the Roman Catholic Diocese of Syracuse; former president of American Association of Homes for the Aging.

Sharon M. Fujii, Ph. D., of Santa Monica, Calif.; principal investigator for Pacific Asian elderly research project.

Frank B. Henderson, of Worthington, Pa.; director, nutrition services, Armstrong County Community Action Agency; chairman, building committee, board of directors of Armstrong County Health Center.

Seldon G. Hill, of Orlando, Fla.; member of the regional areawide planning council on the aging; past president and board member, Retired Citizens Association.

Harry S. Holland, of Phoenix, Ariz.; retired from Social Security Administration; chairman of Governor's Task Force on Retirement and Aging.

Hobart C. Jackson, of Philadelphia, Pa.; formerly executive vice president and director, Stephen Smith Geriatric Center, founder and first chairman of the National Caucus on the Black Aged and member of its executive committee (now deceased).

John B. Martin, of Chevy Chase, Md.; former Commissioner on Aging; legislative consultant to the National Retired Teachers Association and the American Association of Retired Persons.

Garson Meyers, of Rochester, N.Y.; retired executive of Eastman Kodak; past president of the National Council on the Aging; chairman, advisory committee, New York State Office of Aging; chairman of the board, Genesee Savings and Loan Association.

Bernard E. Nash, of Camp Springs, Md.; program consultant and former executive director of the National Retired Teachers Association and the American Association of Retired Persons; former president, International Federation on Aging.

Frell M. Owl, of Cherokee, N.C., retred from the Bureau of Indian Affairs; member of the Indian Advisory Council of the U.S. Senate Special Committee on Aging.

Lennie-Marie P. Tolliver, of Oklahoma City, Okla.; professor and associate director, School or Social Works, the University of Oklahoma; member, Salvation Army Senior Centers' Board of Directors, Oklahoma City.

Nat T. Winston, Jr., M.D., of Nashville, Tenn.; vice president, Hospital Affiliates International; former State commissioner of mental health in Tennessee.

COUNCIL ROSTER: AFTER JUNE 26, 1978

Chairman, Nelson H. Cruikshank; Vice Chairman, James T. Sykes (Elected at July 26 meeting).

MEMBERS

Bertha S. Adkins (term continued).

Nelson H. Cruikshank (term continued).

Dorothy L. Devereux (term continued).

Fannie V. Dorsey, of Owensboro, Ky.; retired teacher; past vice president, Owensboro League of Women Voters; chairperson, Kentucky Institute for Aging.

Charles J. Fahey (term continued).

Harry S. Holland (term continued).

Mary A. Marshall, of Arlington, Va.; member, house of delegates, Commonwealth of Virginia; former economist, Antitrust Division, U.S. Department of Justice; former director, Metropolitan Council of Governments, Washington, D.C.

John B. Martin (term continued).

Walter L. Moffett, of Kamiah, Idaho; director, Nez Perce Tribal Housing Authority; past area vice president, National Congress of American Indians; Past Sanitarian, Division of Indian Health, U.S. Public Health.

Bernice L. Neugarten, Ph. D., of Chicago, Ill.; professor, and member, committee on human development, University of Chicago; former member, National Institute on Aging Advisory Council; past president, Gerontological Society.

Frell M. Owl (term continued).

James T. Sykes, of Madison, Wis., director of public service, the Wisconsin Cheesman; former chairman, Wisconsin Board on Aging.

Fernando M. Torres-Gil, Ph. D., of Alhambra, Calif.; director, research and utilization, Andrus Gerontology Center; treasurer, Western Gerontological Society.

Wesley C. Uhlman of Seattle, Wash.; attorney; former mayor of Seattle, Wash.; former chairman, Task Force on Aging, U.S. Conference of Mayors.

Nat T. Winston (term continued).

COUNCIL SUBUNITS

The Council has four standing committees which were able to meet at least once during 1978. The list of committees, membership, and responsibilities are as follows:

SENIOR SERVICES

Chairman, James T. Sykes. Members: Fannie B. Dorsey, Harry S. Holland, and Frell M. Owl.

This committee has the major task of reviewing policy issues afffecting older people in such areas as housing, social security, welfare reform and employment. This committee made recommendations to the Council on the course of action to be taken with respect to the asset study (to be discussed later in this report). Also, Chairman Sykes appointed a special task force consisting of members from both the Senior Services and Special Aging Populations Committees to study policy issues affecting the rural elderly.

LONG-TERM CARE

Chairman, Charles J. Fahey. Members: Mary A. Marshall and Nat T. Winston, Jr., M.D.

This committee has responsibility for appraising existing and future personnel needs in the field of aging, and development of recommendations for long-term care needs and services for the elderly. A discussion of the Committee's work toward the development of a national policy on long-term care and health manpower needs is presented later in this report.

POLICY DEVELOPMENT AND PROGRAM EVALUATION

Chairman, Wesley C. Uhlman. Members: Bertha S. Adkins, John B. Martin, and Bernice L. Neugarten.

This committee is responsible for evaluation, research and policy analysis. It reviews findings and makes suggestions to the Council for action which may result in recommendations to the President, the Congress, the Secretary of HEW and the Commissioner on Aging. This committee will participate in the development of the mandated study of the Council as required by the 1978 amendments to the Older Americans Act.

SPECIAL AGING POPULATIONS

Chairman, Fernando M. Torres-Gil. Members: Dorothy L. Devereux, and Walter L. Moffett.

This committee is concerned with those segments of the aging population having different life problems—access to resources, distinctive cultures and various problems requiring unusual social and economic support. Specifically, this committee is concerned with policy issues affecting low-income and minority elderly and the rural elderly. It has developed plans for convening a series of regional hearings in 1979 on policy pertaining to the minority elderly. Also, this committee reviewed and offered specific recommendations to the Council on two continuing projects: the minority elderly and frail elderly studies.

TASK FORCE AND/OR SPECIAL AD HOC COMMITTEES

(1) Task Force on Rural Elderly: Convener, Fannie B. Dorsey; members: Walter L. Moffett and James T. Sykes.

This task force is concerned with the identification and study of policy issues faced by older persons in rural America. The task force will recommend suggested directions in which the Council might take action with respect to such concerns.

(2) Personnel Committee: Chairman, Fernando M. Torres-Gil; members: Mary A. Marshall and John B. Martin.

The Personnel Committee is responsible for approving general personnel policies of the Council.

1978 COUNCIL MEETINGS

The Council held the four meetings called for by the Older Americans Act in Washington, D.C.: July 25, 26, 27, and 28; September 26 and 27; October 26 and 27; and December 4 and 5.

1978 COMMITTEE MEETINGS IN WASHINGTON, D.C.

Committee:	
Senior Services	September 6.
Long Term Care	September 11, October 13.
Special Aging Populations	September 15.
Policy Development and Program Evaluation	September 25.

All regular Council and committee meetings were announced in the Federal Register and notices of the meetings sent to representatives of national organizations and to staff of various Federal agencies, congressional members and committees with a special interest and responsibility in the field. Representatives of these groups plus the general public usually attend Council meetings. "Aging Magazine," the publication of the Administration on Aging, regularly reports Council activities. Documents relevant to the Council's official actions are maintained in the office of the Council Secretariat and are available to the public.

PART 2. MAJOR COUNCIL ACTIONS

OVERVIEW

This annual report marks the fifth such issuance by the Federal Council on the Aging. It describes the Council's activities during 1978 and, with its predecessor reports, chronicles the activities and views of 15 citizens who are advocates for older Americans.

Because the Council has now been in operation for almost 5 years, it has built up a series of continuing issues and projects which extend beyond a narrow interest or the 1-year span of an annual report. These projects, which usually involve outside studies, consultants, and contractors, are the Council's way of identifying and addressing emerging and long term issues affecting the elderly. The projects are described elsewhere in this report.

This report also records the Council's actions on matters of importance to the elderly during 1978. For example:

AGE DISCRIMINATION

The Age Discrimination Act of 1975 (title III of the Older Americans Act Amendments of 1975) prohibited "unreasonable" discrimination based on age in programs and activities receiving Federal financial assistance.

Council members felt that age discrimination was without qualification as to "reasonableness" or "unreasonableness" and the following resolution was adopted at its July 1978 meeting:

"The FCA endorses those principles of H.R. 12255 (Comprehensive Older Americans Act Amendments of 1978) which prohibit discrimination on the basis of age, without qualification as to the terms reasonableness or unreasonableness.

"The FCA also endorses those principles of H.R. 12255 as amended which permit private legal actions as may be necessary to achieve that statutory objective of the act."

The Chairman, by direction of the members, sent the resolution to the House and Senate Conference Committee acting on the Older Americans Act Amendments as an expression of the Council's recommended policy.

MANDATED STUDIES

The Chairman, on behalf of the Council, recommended to the House and Senate Conference Committee that the requirements of H.R. 12255 mandating approximately 10 specific studies by the Council be deleted inasmuch as the Council lacked the staff and funds to deal with them on a substantive basis. The conference, in principle, acceded to the Chairman's recommendation, and combined the list of mandated studies into one overall comprehensive study of programs under the Older Americans Act which includes optional subparts (see description of mandated study in part 4 of this report).

The Council's Policy Development and Program Evaluation Committee was given the responsibility to review options for fulfilling the requirements of the mandated study.

FEDERAL TRADE COMMISSION PROPOSED TRADE REGULATION RULE FOR THE HEARING AID/INDUSTRY

In June 1976, Miss Bertha Adkins, then Chairman of the Federal Council, testified before the Federal Trade Commission (FTC) on the proposed trade regulation rule for the hearing aid industry. The trade regulation rule focused on two areas of consumer protection: (1) the buyer's right to cancel, and (2) the requirement of written consent to a salesman's visit. The testimony supported these regulations in order to protect vulnerable hearing-impaired older persons from purchasing ineffectual and/or unnecessary hearing aids.

Reflecting continued interest in the trade regulation rule, the Council at its September 26 meeting was briefed by a representative of the Bureau of Consumer Protection on the hearing aid industry staff report.

The Council expressed interest in three aspects of the proposed rule: (1) the staff presentation on the special vulnerability of many elderly persons; (2) the clear language format requirements of the consumer notice; and (3) the staff analysis of the economic impact of the buyer's right to cancel rule.

At the December meeting, the Council passed a motion that it concur in the recommendation of the Federal Trade Commission with respect to the buyer's right to cancel and the requirement of express written consent prior to a sales visit. It was further agreed that members would have an opportunity to submit further comments by January 10, 1979, or else it would be assumed that the Council's motion would be the position for submission to the FTC.

HOSPITAL COST CONTAINMENT

One of the major concerns today is the rapidly increasing costs of hospital care. The administration fought for a hospital cost containment bill in the last session of Congress.

At its September meeting, the Council discussed the effects of rising hospital care costs for the elderly. It was noted that the elderly carried a disproportionate load of the total costs of hospital expenses. Efforts have been made, and renewed through the years, for some kind of national health insurance, but the administration decided not to sponsor national health insurance legislation during the 95th session of Congress. Consequently, on September 26, 1978, the Council adopted a resolution stating:

"The Federal Council on the Aging endorses in principle the provision of the administration's hospital cost containment proposals now before the Senate. The Federal Council strongly urges the Congress to act now to pass the legislation."

The Council's resolution was presented to the administration at a special White House meeting on hospital cost containment. The Congress, however, did not enact hospital cost containment legislation at its last session.

COMPREHENSIVE EMPLOYMENT TRAINING ACT (CETA)

At its September meeting, the Council considered problems in the Comprehensive Employment Training Act with respect to services and projects for older persons. At that time, Congress was considering amendments to the original act that would deal specifically with middle-aged and older workers. The Council directed its chairman to communicate with the House and Senate Conference Committee on the CETA amendments, expressing the Council's support of legislation directing the Secretary of Labor to assist in overcoming obstacles to employment often confronting older workers due to obsolete skills, employer reluctance to hire or lack of job opportunities. The Council felt that inclusion of such provisions had long been needed in basic CETA employment legislation, and would mean that an unemployed or underemployed older worker would have greater opportunity for finding employment.

The legislation, as enacted, directs the Secretary of Labor to develop employment and training policies for the middle-aged and older worker, and to more equitably apportion employment and training resources.

The Council's discussion of the CETA at its December meeting was characterized by an expressed concern that the Department of Labor include in its regulations enough specificity to insure that prime sponsors follow the intent of Congress with respect to training and services for older workers.

The Council adopted a motion directing the Chairman to submit written comments to the Secretary of Labor urging the adoption of CETA regulations for improving training opportunities and job placement for older workers. In addition to the communication to the Secretary of Labor, the Council also requested that a meeting between the Chairman, Council member John Martin and the Secretary of Labor be scheduled to review the CETA regulations.

INFLATION

In October, the President set forth the administration's policy on inflation. The Council expressed concern that inflation, more than any other issue, affects older people the hardest in terms of health costs, housing, transportation, et cetera. The Council felt that it should provide support with respect to the administration's statements and policies concerning the fight against inflation—especially as it affects the elderly. Therefore, at its October meeting, the Council adopted the following resolution which was communicated to the President:

"Older Americans have suffered greatly from the inflation that is gripping our Nation. Older people have seen their meager pensions buy less and less. Older people have found their retirement income too small to keep track with rising costs. Therefore, the FCA favors the administration's efforts to slow inflation. The FCA urges the Congress, business and labor to do all within their power to bring inflation under control."

MENTAL HEALTH AND ILLNESS OF THE ELDERLY

At the recommendation of the Policy Development and Program Evaluation Committee, the Council plans to publish as a single publication in 1979 the Reports of the Secretary's Committee on Mental Health and Illness of the Elderly and the President's Commission on Mental Health. The Secretary's committee basically addressed itself to three items—the future needs for mental health facilities in manpower, research and training to meet mental health care needs of elderly persons; the proper care of elderly persons in mental institutions or who have been discharged from such institutions; and proposals for implementing the recommendations of the 1971 White House Conference on Aging as it concerns the mental health of the elderly.

Both reports recommend eliminating the present distinctions between mental and physical health in medicare and medicaid and urge priority attention to mental health for the elderly.

On recommendation of the Council, the Chairman sent a letter to the Secretary of HEW expressing the Council's interest in publishing the reports. The Secretary responded positively to the Council's request and the publication is expected to be available by the fall of 1979.

SOCIAL SECURITY

The Council, during its December meeting, expressed its concern about possible proposals to reduce social security benefits as a part of the administration's effort to reduce the deficit position of the budget for fiscal year 1980.

Inasmuch as the Congress had directed that "the Council shall advise and assist the President on matters relating to the special needs of older Americans," the Council asked the Chairman to convey its conviction that even though the operation of the social security trust funds are combined with the general operations of the Federal Government in the unified Federal Budget, policy decisions affecting the social security program should be based on the objectives of the program rather than on any effect such decisions might have on the Federal budget.

The Council took note of the fact that the Statutory Advisory Council on Social Security was established by the Secretary of HEW in February of 1978, and that its study and review of the social security program was still in progress. It was noted also that a second advisory body, the National Commission on Social Security, had been established under provisions of the 1977 Social Security Amendments. Accordingly, the Council requested the Chairman to convey to the President its recommendation that substantive changes in the social security program be based on the objectives of the program, and that such changes should not be initiated until the recommendations of these advisory bodies become available.

ADMINISTRATION ON AGING (AOA) NATIONAL WORKING CONFERENCE

The Council received an invitation from Robert C. Benedict, the Commissioner of AOA, to cosponsor the National Working Conference of the AOA which was held November 8–11, 1978.

Among the goals for the Conference were:

—to review the decisions of the Congress under the 1978 Amendments to the Older Americans Act.

—to generate recommendations on the mission and function of AOA.

—to develop suggested regulations for AOA program guidance over the next several years.

Council members responded positively to the invitation to participate, but expressed hope that the Council's role would be made clear with respect to its program evaluation mandate under the new Older Americans Act, and that it should be careful not to compromise its responsibility to evaluate programs under the act. Distinctions between the Council's policy and oversight role and AOA's administrative role should be maintained, the Council felt. The Council agreed to participate in the working conference, emphasizing that any views expressed would be those of individual participants and not necessarily those of the Council. Chairman Cruikshank was directed by the Council to communicate this to Commissioner Benedict.

PART 3. UNFINISHED BUSINESS

MINORITY POLICY STUDY

In October of 1977, the Council contracted with the Human Resources Corporation of San Francisco, a minority firm, to conduct a study on policy issues concerning the minority elderly. The contractor was asked specifically:

—To formulate policy recommendations which seek to achieve equity for minority elderly.

—To formulate alternative policy recommendations to the Council's frail elderly proposal (if warranted).

—To identify data gaps and research needs in these and related areas.

The recommendations were to be derived from a review of the following sources.

—Federal benefit and service programs.

—The Federal Council on the Aging's frail elderly proposal.

—The 1971 White House Conference on Aging recommendations.

—The available minority aging literature, including studies, hearings, reports, et cetera.

The Human Resources Corporation worked with a team of consultants with expertise in minority againg, especially in the areas of research and policy analysis. In addition, the contractor sought input from the members of an advisory committee; representatives of major Federal agencies; national minority organizations; and selected community and advocacy groups.

STUDY PRODUCTS

The study generated six papers and an executive summary. The papers consisted of two background reports and four ethnic-specific papers. The purpose of the two background papers was to examine the various issues considered crucial to understanding policies affecting the minority elderly. One background paper, entitled, "The Knowledge Base for Planning Services to Minority Elderly," examines the available data on minorities; provides a critique of methodologies; identifies research gaps and offers a critique of theoretical models as they impact on understanding aging in minority communities.

The other background paper, entitled, "Minority Group Issues and Benefit Programs for the Elderly," provides an overview of Federal policies and programs as they affect the minority elderly.

The four ethnic-specific papers focus separately on the American Indian, black, Latino, and Pacific/Asian elderly. Included are examinations of bilingual-bicultural issues, natural support systems, issues of life expectancy, and the applicability of the Council's frail elderly proposal.

The executive summary synthesizes the significant issues, findings, and recommendations from the background and ethnic-specific papers. It also identifies research gaps and suggests priorities in research needs.

This minority policy study for the Council represents a significant first step in beginning to look critically at the impact of Federal policies on the minority elderly. Ideally, Federal policies should be reviewed on a continuing basis to determine whether they impact equitably on the minority older population in this country. If, on the basis of such reviews, it is discovered that they do not impact equitably on the minority elderly, then the necessary steps should be taken by the Council and others.

DISPOSITION OF MINORITY STUDY

At its first meeting in July 1978, the Council voted that the minority policy study be reviewed by the Special Aging Populations Committee for appropriate recommendations with respect to its final disposition.

In December 1978, the Special Aging Populations Committee, with Council approval, mailed copies of the minority elderly policy report to selected reviewers in the aging network. The reviewers were urged to review the report and provide critique. The Council wanted to have the benefit of these critiques before its final deliberations on the report's recommendations.

NATIONAL POLICY FOR THE FRAIL ELDERLY

In its first annual report issued in 1975, the Council identified as a priority concern that group among the elderly—usually the oldest of older Americans—with an accumulation of health, social, economic, and environmental problems which impede their independent living to the extent that they need continuing personal assistance.

During the past 4 years, the first 3 under the leadership of Monsignor Charles Fahey, then Chairman of the Task Force on the Frail Elderly, and the past year under the direction of Fernando Torres-Gil, the Council developed a conceptual framework within which to make a determination of a national policy regarding services to the frail elderly. As noted in previous reports, the Council claims no special originality for the name. It was selected because of the need for a dramatic term to focus attention on this very special grouping of the elderly.

At the July 1978 Council meeting, the Special Aging Populations Committee, chaired by Mrs. Torres-Gil, was given the responsibility of proposing recommendations for final disposition of the frail elderly report. The committee, thanks largely to the input of the former task force chairman, Monsignor Fahey, proposed the following options for Council consideration:

—The Council could translate the principles, as well as various concepts in the background material, into a statutory draft for possible introduction either by the administration or by some interested Member of Congress. The submission of such legislation would further clarify the issues and would give rise to more extensive debate on the concepts which are involved in the frail elderly project.

—The Council could decide to take the principles cited in the frail elderly report and use them as criteria for measuring administrative and legislative proposals in the field.

—A combination of both approaches might prove feasible.

In its deliberation of these options, the chairman suggested that the frail elderly report be sent to one of the congressional Committees on Aging for possible publication as a committee report originated by the Council, with the recommendation that hearings be held on the subject.

GENERAL OBSERVATIONS

The frail elderly report is an interim step in the Council's activities in regard to the frail elderly, designed to provide a broader opportunity for choices with respect to future activities in this specialized area.

From the outset, the project was designed to engage the best national thinking available in evolving an enlightened public policy position regarding those individuals who are most vulnerable by reason of age and infirmity. And while the Council is primarily concerned with the elderly, it is also aware of those frail persons who are not old, but whose plight is similar to that of many who are both frail and elderly. An important policy question concerns the development of an age-related service for the "frail" as opposed to one that would provide support systems for all regardless of age.

From the beginning, the establishment of a presumptive eligibility reaching all persons above a certain age (over 75) was perceived as a politically viable way to define a system which would reach those ailing elderly most in need. It is clear from the various background material, as well as from the policy actions adopted by the Council, that there is deep concern for all the frail and the elderly—especially those who are over 75. Further attention should be given to simplified methods of establishing eligibility so that appropriate services will be available to all other persons in need.

The Council views with special concern the condition of those persons in our society belonging to various subgroups whose longevity is different from the overall population. There is need of a method to assure the same services available to the over 75 population as to those of various ethnic and/or minority backgrounds whose need may arise at an earlier age.

ASSET TESTING STUDY

When the Federal Council on the Aging was established under the 1973 Amendments to the Older Americans Act, the Congress charged it to:

". . . undertake a study of the interrelationships of benefit programs for the elderly operated by Federal, State and local government agencies."

This study, entitled, "The Interrelationships of Benefit Programs for the Elderly," was duly carried out and transmitted to the President on December 29, 1975.

One recommendation in that report was a decision by the Council to formulate an approach for determining the manner in which government benefits should most equitably be distributed. The Council stated that it would "initiate a study of the philosophical and administrative rationale connected with the ways in which assets and asset income are considered in determining eligibility for benefit programs and the various options available to reduce the inequities in the existing asset tests."

As a first step, the Council commissioned a paper by Mrs. Betty Duskin, an economist with the National Council of Senior Citizens. Her paper reviewed various philosophies of income maintenance and dealt with the economic basis asset tests, administrative complexity, and costs. The Council accepted Mrs. Duskin's recommendations that a number of study papers be commissioned with respect to asset tests for the elderly.

In 1977, the Council contracted with the Institute for Research on Poverty at the University of Wisconsin to organize a conference on assets, the participants being experts in economics, law, and social work. This conference was held at the University of Wisconsin in May 1977. In addition, Dr. Robert Lampman, professor of economics at the University of Wisconsin, was engaged by the Council to develop recommendations which might serve as eventual policy guidance on asset testing for the executive and legislative branches of Government.

While no final conclusions were reached at the conference, some general agreement was developed on the following points:

—Assets cannot be ignored since present holdings are important, in addition to income, when considering the economic status of individuals.

—Benefits should not have an arbitrary cutoff when assets reach some arbitrary limit—particularly when exemptions vary by type of asset.

—The exemption of the total value of a home is not supportable since this gives an unreasonable advantage to home owners as compared to those who invest in other assets.

Following the conference, Professor Lampman was asked by the Council to develop recommendations and options for changes in existing Federal policies on asset testing in order to enhance equity considerations. His recommendations with respect to the treatment of assets and income from assets are reported in two Council publications: "1977 Annual Report to the President" and "The Treatment of Asset and Income from Assets in Income-Conditioned Government Benefit Programs."

At the December 1977 meeting, Professor Lampman reported on the general questions of equity in asset testing. In addition to the Council's acceptance of the report, it was further determined that it would be useful to obtain reactions to the Lampam report from Federal officials responsible for administering means-tested programs. Seven Federal agencies were requested to respond to the the recommmndations in the report. Eventually, comments were received from the Veterans' Administration, Department of Housing and Urban Development, Department of Agriculture, and four HEW agencies—Health Care Financing Administration, Office of the Assistant Secretary for Planning and Evaluation, Administration for Public Services, anl the Social Security Administration. While the responses may not represent a consensus on the recommendations, they are generally supportive of part or all the concepts contained in the report. The Council reviewed the highlights of these comments from the seven agencies at the July meeting and moved that the project be referred to the senior services committee with a report on followup recommendations due at a future Council meeting.

At the December 1978 meeting, Professor Lampman presented his recommendations on equity in asset testing. They were as follows:

—Reduce the basic benefit-reduction rate on nonearned income from 100 percent to 75 percent.

—Set $35,000 per couple as the limit on all assets, including an owner-occupied house, to be eligible for benefits under federally-assisted programs.

—Define "countable income" to include net imputed rent of an owner-occupied house.

—Eliminate the one-third benefit reduction for living in the home of a relative.

—Adjust asset limits annually for changes in the Consumer Price Index (CPI).

—Encourage investigation into the effect of federally-guaranteed housing annuity plans.

After lengthy debate, the Council decided that equity considerations were not the only issues involved and that the recommendations should consider income adequacy topics. The senior services committee of the Council was directed to consider the issue of income adequacy and report at a future Council meeting.

PERSONNEL NEEDS IN THE FIELD OF AGING

In 1977, the Council awarded a contract to CSF Ltd., a Rockville, Md., management consultant service to the health care industry, to analyze manpower issues in the delivery of health services to the elderly and to develop public policy recommendations toward the provision of appropriate health care services for the aging.

The study presented to the Council consists of three sections: (1) Final report for study of health manpower needs for services to older Americans; (2) analysis of quantitative methods for determination of health manpower needs of older Americans; and (3) supplemental review of literature and bibliography.

Major policy issue categories of the study were primarly based on concerns expressed by the Council. The recommendations are linked to each of these major policy issue categories: Health and social models of health care delivery; frail elderly; minority elderly; health manpower training needs; maldistribution of health services; specialization of health manpower; comprehensive program of health care delivery; national health insurance; and availability of data to project the health manpower needs of older Americans.

The policy recommendations address themselves to three distinct concerns related to providing health care services for the elderly:

—The scope and orientation of the health care services offered.

—The system for coordinating and delivering these health care services.

—Further required research into service and delivery system requirements.

The final report was completed in 1978 and approved by the Council at its September meeting.

LONG-TERM CARE

The Council approved the Long-Term Care Committee's recommendations to obtain outside advice and consultation from selected individuals to assist in a process leading to the creation of a Council position on long-term care for the 1981 White House Conference on Aging. The end product of these consultations would be a Council document delineating its position on long-term care, the process by which the Council's position was developed as well as the issues and problems considered.

The Long-Term Care Committee proposed to implement policy development by first convening a meeting of Federal officials having policymaking responsibilities in the field of long-term care. The Council recognizes that problems and issues in long-term care are greater than those treated in individual programs and/or departments. The Council plans to seek advice and consultation from the private sector also. Through its long-term care activities, the Council hopes to provide a forum for the development of a comprehensive plan in this vital area.

It is expected that both the public and private sectors will participate with the Council on a continuing basis until an effective long-term care policy has been developed. Since a coordinated, comprehensive policy of long-term care has been elusive, the Council looks to the 1981 White House Conference on Aging as a useful forum in which to help formulate national thinking on the subject.

PART 4. NEW BUSINESS

THE CONGRESSIONALLY MANDATED STUDY

The 1978 amendments to the Older Americans Act require the Federal Council on the Aging to undertake a thorough evaluation and study of programs conducted under the act. The legislation requires the study to include:

—An examination of the fundamental purposes of such programs, and the effectiveness of such programs in attaining such purposes.

—An analysis of the means to identify accurately the elderly population in greatest need of such programs.

—An analysis of number and incidence of low-income and minority participants in such programs.

The study may also include:

—An exploration of alternative methods for allocating funds under the programs to States, State agencies on aging, and area agencies on aging, in an equitable and efficient manner which will accurately reflect current conditions and insure that the funds reach the areas of greatest current need and are effectively used for those areas.

—An analysis of the need for area agencies on aging to provide direct services within the planning and service area.

—An analysis of the number of nonelderly handicapped in need of home-delivered meals services.

Work undertaken on the study (status) to date includes:

—Development of a draft statement of work.

—Completion of proposals for alternative approaches.

—Requests of 14 Federal agencies to provide information on studies in aging programs.

—A request for assistance to the Department of Health, Education, and Welfare in defining the scope of the study.

The Council plans by mid-1979 to have developed work specifications on what will be used, an inventory of available information, what should be measured, problem areas, program information, location of data, and cost. The preliminary report will define the scope of the work, provide preliminary findings and plans for proceeding with the study.

THE WHITE HOUSE CONFERENCE ON AGING

The 1978 amendments to the Older Americans Act provides authority for the President to call a White House Conference on Aging in 1981 to develop recommendations on income, economics, health, housing, social services, long-term care, employment, retirement policy, and research programs for further action in the field of aging.

The Secretary of the Department of Health, Education, and Welfare is required to establish an advisory committee to the Conference which will include representation from the Federal Council on the Aging and other public groups and private nonprofit organizations concerned with aging.

In reviewing the legislation authorizing the Conference, the Council forwarded a series of recommendations to the Secretary of HEW, including recommendations that the Conference address issues which are broad in scope and have implications for all persons by addressing the broader issues arising from this Nation's aging society. The Council recommended that the Conference's theme be "The Aging Society."

It was also recommended that each Council member be named to the Advisory Council of the 1981 White House Conference.

In response to the recommendation, the Secretary said that consideration would be given to Council members serving on the Advisory Council.

THE RURAL ELDERLY

At its October meeting, the Council formally approved formation of a special task force whose purpose is to devote attention to the unique needs and special problems of the rural elderly. As previously mentioned, the Task Force on Rural Elderly is under the auspices of both the Special Aging Populations and Senior Services Committees of the Council.

On November 9, 1978, the Council's Rural Elderly Task Force convened an informal luncheon meeting at the Administration on Aging's national working conference called "Counting Down—Implementation of the New Amendments to the Older Americans Act." The task force organized the luncheon meeting in order to gain assistance in identifying the major areas of concern regarding the rural elderly.

Council member Mrs. Fannie Dorsey, who convened the task force, requested the participants' assistance in defining the extent of the problems faced by older persons in rural America and suggested directions in which the Council might go wih respect to the rural elderly. She asked the conferees to cooperate with the Council and each other in finding appropriate and workable solutions.

Representatives of the following organizations attended the luncheon:

National Caucus on the Black Aging;
Spencer, Iowa Area Agency on Aging;
USDA, Farmers Home Administration;
National Association of Counties;
Senate Special Committee on Aging;
Administration on Aging;
National Farmers Union;

Council of State Governments;
National Conference on State Legislatures;
USDHUD, Elderly Programs Division;
National Council on Aging;
National Association of Area Agencies on Aging; and
Vermont Office on Aging.

In considering the specialized problems of the rural elderly, the participants were asked to identify the major difficulties facing this group. The problems most often cited were transportation accessibility, lack of funds, and the lack of a consistent Federal strategy to deal with the situation. Other concerns included the lack of advocacy, excessive paperwork and "redtape," housing, untapped skills of the rural elderly, and special aging populations such as elderly blacks, Indians, and Hispanics.

The participants were also asked to describe what their organizations were doing to respond to the problems of the rural elderly. Various approaches to relieving the problems of the rural elderly were discussed and in time will comprise part of a study by the Rural Elderly Task Force.

NEW PROJECTS

Without an active council for more than half of 1978, much of the contract effort involved the completion or continuation of previous projects.

The major new project initiated in 1978 was a study on "The Development of Procedures and Criteria for Evaluating Federal Policies on the Aging."

The Older Americans Act of 1965, as amended, provides that the Council shall "* * * review and evaluate, on a continuing basis, Federal policies regarding the aging and programs and other activities conducted or assisted by all Federal departments and agencies for the purpose of appraising their value and their impact on the lives of older Americans * * *."

A contract was awarded to Pacific Consultants, a minority firm with much experience and expertise in conducting technical projects, located in Washington, D.C.

The study products expected from the project are: (1) A draft handbook for Council evaluation of Federal efforts on behalf of the aging; and (2) a FCA operational procedure manual for gathering, organizing, disseminating, and utilizing information on (a) problems and needs of older persons, (b) Federal responses to those problems and needs, and (c) other governmental and nongovernmental responses.

In addition to the above major contract, the Council utilized the services of the following specialized experts: Dr. Robert Lampman, professor of economics, University of Wisconsin, for the asset study; Mrs. Dorothea Lewis, editing consultant, for the frail elderly report; and Mr. Arthur Boyd, management consultant, for the FCA orientation session.

PART 5. MISCELLANEOUS

SUPPORTING SERVICES AND STAFF

THE PLACE OF THE COUNCIL WITHIN THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

For the period covered by this report, the Council was operating under the provisions of the Older Americans Act of 1973, as amended. This act provides that the Secretary of the Department of Health, Education, and Welfare (HEW) and the Commissioner on Aging make available to the Council such staff, information, and other assistance as it may require to carry out its activities. Clearly, the intent of Congress at that time was that the activities of the Administration on Aging (AoA) and the FCA be coordinated. This was further underscored by the provision that both the Secretary of HEW and the Commissioner on Aging be ex officio members of the Council.

At the same time, it was equally clear that the Congress meant the Council to have certain oversight responsibilities which included some evaluation of programs administered by the AoA and other agencies in HEW. Obviously, these functions required a certain amount of independence on the part of the Council from HEW.

As the act was translated into administrative practice, however, the Council found itself in a subordinate position—administratively responsible to the Secretary only through two other layers of the bureaucracy—the AoA and the Office of Human Development Services of which AoA is part.

Admittedly, there have been some advantages to this arrangement. For example, the placement of the Secretariat in AoA and the Office of Human Development Services provides informal, as well as formal, utilization of their staff and support services. The Committee Management Office in the Office of the Secretary aids in carrying out the provisions of the Federal Advisory Committee Act.

There are, however, important disadvantages. As the Office of Human Development Services and the Secretary are in a position to provide the services designated in the act, they are also in a position to withhold such services and support. This militates significantly against the independence which Congress meant the Council to have in its oversight capacity.

In the reauthorization of the Older Americans Act of 1978, the Congress reemphasized its recognition of the independence of the Council. First, the new act repealed the provision that the Secretary and the Commissioner on Aging be ex officio members of the Council. Second, the new act repealed the provision that the Secretary and the Commissioner make available to the Council such staff, information, and assistance as needed and substituted a provision that the Council have staff appointed by the chairman and that all Federal departments make available to the Council such information and other assistance as it may require to carry out its activities.

While the intent is clear, HEW continues to interpret the act, for all practical purposes, in accordance with the pre-1978 act. If the Council is to meet its obligations effectively, means must be found to implement the clear intent of Congress with respect to the need to remove the Council from its subservient and dependent administrative position.

BUDGET AND SUPPLEMENTARY STAFF

Short-term employees and contractors have been utilized to assist with certain Council projects such as the assets study, national policy for services to the frail elderly, health manpower needs, and policy issues concerning the minority elderly. The Council's budget for fiscal year 1978 of $450,000 was provided within the AoA appropriations. The Administration on Aging's fiscal year 1979 budget retains the same funding level.

ACTIVITIES OF COUNCIL MEMBERS

As part of the general responsibility of the Federal Council on the Aging to inform the public of the needs and contributions of Older Americans, members of the Council participated in a number of activities. Mr. Cruikshank's major engagements included:

Appeared on the "Over Easy" TV show, San Francisco, Calif., January 24.
Speaker at the American Bar Association,. New Orleans, La., February 12.
Speaker at the Metropolitan Chicago Forum on Aging and addressed the General Assembly of the Seniors' Alert Organization, Chicago, Ill., March 10.
Addressed the Second National Conference on Aging and Blindness, Atlanta, Ga., March 28.
Speaker at the Western Gerontological Society's 25th Annual Conference, Tucson, Ariz., April 12.
Speaker at the 28th Annual Conference of the National Council on Aging, St. Louis, Mo., April 17.
Speaker at Duke University, Center for the Study of Aging and Human Development, Asheville, N.C., May 20.
Addressed the N4A National Conference, Albuquerque, N. Mex., July 13.
Keynote speaker at Senior Citizens Rally and Workshops, Los Angeles, Calif., August 26.
Speaker at the Second Annual Senior Citizens Resource Fair, Minneapolis, Minn., October 20.
Guest Speaker at Midwest Regional Conference of the United Church Board for Homeland Ministries and the United Church Office for Church in Society, Des Moines, Iowa, November 28.

Mr. Cruikshank also testified on behalf of the Council at two oversight and extension hearings on the Older Americans Act before both the Subcommittee on Aging of the Senate Committee on Human Resources, February 1, 1978, and the Subcommittee on Select Education of the Committee on Education and Labor, U.S. House of Representatives, March 6, 1978.

Aside from the Chairman's activities, other Council members were quite similar and the range of their participation included: Attending national aging meetings such as the National Council on Aging, the Gerontological Society meeting and the Western Gerontological Society meeting; attending the AOA working conference on the 1978 older Americans amendments; delivering keynote addresses at aging meetings and serving on various commissions and boards at the local, State, and Federal levels on behalf of older people.

TRIBUTE TO HOBART C. JACKSON

The Council remembers with affection and admiration Hobart C. Jackson who died March 10, 1978.

A member of the Council from the beginning and Founder and Past Chairman of the National Caucus on the Black Aged, he represented with vigor and compassion the interests of all people, always within context of his all-embracing concern for the elderly without regard to race or creed.

Appendix 2

REPORTS FROM FEDERAL DEPARTMENTS AND AGENCIES

ITEM 1. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

FEBRUARY 5, 1979.

DEAR SENATOR CHILES: We appreciate the opportunity to share program activities and developments undertaken by the Department to improve the quality of life for older Americans. Enclosed are summary reports indicating agency support and implementation of the Department's commitment to the needs of the elderly.

If we can be of additional assistance, please do not hesitate to call on us.

Sincerely,

ALEX P. MERCURE,
Assistant Secretary.

Enclosures.

FOREST SERVICE

The U.S. Department of Agriculture Forest Service participates in the senior community service employment program (SCSEP), administered under title IX of the Older Americans Act. It is commonly known as the senior conservation employment program which is a cooperative program with the Department of Labor for economically disadvantaged senior citizens, primarily in rural areas. Its purpose is to provide a supplemental income, work experience, and training to enrollees. These enrollees also receive personal and job-related counseling, supervision, yearly physical examinations, and in some cases, placement in regular unsubsidized jobs. In return, valuable conservation projects are completed on National Forest lands.

The program seeks to provide a supplemental income to senior citizens; demonstrate and utilize the potentially great value of senior citizens to society in general . . . and to rural communities in particular; and provide work experience that will encourage and help rural employers to hire more senior workers.

Under the SCSEP, the USDA Forest Service enrolled approximately 3,500 older workers on various conservation projects on National Forest lands and facilities during fiscal year 1978 and conservation work valued at more than $12.3 million.

RURAL ELECTRIFICATION ADMINISTRATION

The function of REA is to provide electric and telephone service to rural areas. In fulfilling our function, however, our interest in rural development extends well beyond merely providing service.

Borrower personnel tend to be community leaders. The manager of a telephone borrower in Maine initiated a project in his community of 300 people, which resulted in the construction of 20 units of low-cost housing for the elderly. REA also participates in State and Federal rural development programs which aid rural residents in general. An REA field employee in Indiana is very active in programs for the elderly which have set standards for such programs in the State of Indiana. His group:

(1) Established the first multipurpose center.

(2) Operated the first on-site cooking program.

(3) Was the first to prepare frozen meals for rural delivery.

(4) Put together a "disaster pack" of nine meals that can be opened by pull tabs on the cans and can be eaten cold if utilities are interrupted by a storm.

These are just two examples of how REA and its borrowers are helping meet the needs of the aging in rural areas.

Although, REA does not offer any programs specifically designed for the aging, it does provide information and technical assistance to those REA-financed electric and telephone systems that are working on such projects as described above.

ECONOMICS, STATISTICS, AND COOPERATIVES SERVICE (ESCS)

ESCS reports the following research on behalf of older Americans.

ECONOMICS

Bylund, Robert; Charles O. Crawford; Nelson L. LeRay; and Elinor M. Caravella: "The Rural Elderly in the United States and the Northeast: A Statistical Report," Northeast Reg. Ctr. for Rural Dev. Publ. 14. The Proc. of the Workshop on Rural Geron. Res. in the Northeast, May 24–27, 1977. July 1978, pp. 14–31.

LeRay, Nelson L.; Charles O. Crawford; Dennis A. Watkins; and Donn A. Derr: "Community Services for Older People in the Rural Northeast," Northeast Reg. Ctr. for Rural Dev. Publ. 14. The Proc. of the Workshop on Rural Geron. Res. in the Northeast, May 24–27, 1977. July 1978, pp. 135–144.

LeRay, Nelson L.; A. E. Luloff; and J. G. Campbell: The Older Population of New Hampshire, Res. Rpt. No. 66, July 1978.

Boehm, William T. and Anthony E. Gallo: "Food Purchasing Patterns of Senior Citizens," National Food Review-No. 4, September 1978.

STATISTICS

Conducts statistical surveys (NORC) for the Agricultural Research Service. These surveys have questions by age groups to determine attitude difference in farm operations.

COOPERATIVES

One activity of the Cooperative Development Division provides technical assistance to craft cooperatives. Frequently, more than half the membership of these organizations is senior citizens.

Two craft cooperatives provided assistance in 1978 were MATCH, Inc., Berea, Ky., and Blue Ridge Hearthside Crafts Associations, Boone, N.C.

The publication, "The Cooperative Approach to Crafts for Senior Citizens," continues to have wide distribution. It is used in response to numerous inquiries from State and Federal agencies, local senior programs, and senior citizens regarding the potential for craft cooperatives for senior citizens.

All of the publications referred to can be obtained from this office.

OFFICE OF EQUAL OPPORTUNITY (OEO)

In January, the proposed government-wide age discrimination regulations that were prepared by the Department of Health, Education and Welfare were distributed to the pertinent USDA agencies for comment. The comments are due to OEO by February 15 for consolidation. The agencies were also asked to identify all age distinctions in their programs and report them to OEO by March 15.

Following publication of final HEW regulations later this year, USDA will then publish regulations of its own pertaining to USDA programs. OEO will prepare the regulations.

The OEO contact for age discrimination is William Payne, 447-3227.

SCIENCE AND EDUCATION ADMINISTRATION (SEA)

Construction plans and programs for the Human Nutrition Research Laboratory to be constructed at Tufts University have been developed during the past year. The general missions of this laboratory are:

(1) To determine how dietary habits and nutritional status influence the onset and rate of progression of normal aging.

(2) To determine ways in which diet, alone or in combination with other factors, can retard or prevent the onset of a variety of degenerative conditions associated with the aging process in America today.

(3) To determine how an optimal diet—in combination with other factors (hereditary, psychological, socioeconomic)—may contribute to youthful vigor and health over an extended lifespan in man.

The laboratory is being planned to accommodate long-term studies on nutrition and aging . . . experimental animal, clinical, and epidemiological, utilizing population groups in the New England area or elsewhere. On the latter point, there have been some preliminary discussions with the Boston VA Normative Aging Study Group.

Our present knowledge of optimal nutrient needs of adults and the elderly is very limited. If protein or micronutrient requirements remain stable with advancing age, the quality of the diet would have to be improved since the quantity consumed decreases. In present society, this is by no means assured; furthermore, retardation of aging or chronic diseases may well suggest particular modifications. It seems reasonable to expect that optimal nutrition influences aging just as it does the earlier life processes of gestation, growth, and development.

Among the specific scientific areas which will be attacked before the new laboratory opens in mid-1981 are:

(1) Epidemiological and clinical studies on the role of nutrients, hormone status, and life-style in the onset and progression of osteoporsis.

(2) Population and clinical studies of the role of nutrients intake in the anemia so prevalent among American elderly.

(3) Clinical and experimental animal studies on nutritional status and the competency of the immune system . . . and the latter's influence on aging and/or associated degenerative diseases.

(4) Clinical studies on the functional integrity of the gastrointestinal tract during the aging process.

We will make an effort to carry out studies of nutrient requirements in a functional context . . . developing new physiological biochemical, or behavioral endpoints of "optimal" intakes.

All program areas will be developed in full concert with advisors from NIH—NIA.

Family Education/Food and Nutrition

Forty-four State Cooperative Extension Services reported that the aging population is a target audience for many home economics educational programs. A nutritionist and a program leader on the Federal Extension staff are liaisons with other agencies and national organizations. They also provide leadership to State programs thru newsletters, State visits and national workshops. Each State has staff members who provide similar support for county Extension home economists.

The following methods were used to reach and teach the aging: newsletters, special interest meetings, workshops, noncredit courses at college week and school days for senior citizens, a series of programs, club or other group programs, television, radio, news releases, individual counseling, publications and fact sheets, correspondence courses, leader training meetings, forums and seminars.

Many States reported *cooperating with other agencies* in an effort to improve the quality and quantity of programs for the aging. Among those listed were: State commissions/divisions on aging, American Red Cross, social service/welfare departments, Neighborhood Outreach, Inc., Food and Drug Administration, dietetics associations, area agencies on aging, colleges and universities, State home economics associations, public housing authorties, health departments, Governor's committee on aging, mental health agencies, ACTION, Institute of Community Development and titles VII, IX and XX programs.

Extension has three "memorandums of understanding" with the Administration on Aging. They relate to energy conservation for the elderly, nutrition education at title VII centers and information and referral programs for the aging. Extension staff members in many States are implementing these memorandums.

Several States have had statewide or multicounty programs for the aging. The Extension Service cosponsored the "Governor's Conference on Aging" in Kansas. This 2-day event offered many educational and recreational programs. South Carolina, Mississippi, and Alabama conduct "college days for senior citizens" on the land-grant campuses. The 3 to 5 day events offer many noncredit courses and activities. In Alabama, 1,700 people were reached through school days programs that were conducted at State parks and on campuses. Many States sponsor senior citizen days at State and county fairs. In North Carolina, a senior adult day camp involved three generations, youth, middle years, and elders. Virginia offers a several day program for elders at 4–H camping facilities. Extension reaches and teaches many senior citizens through the Extension Homemaker Club program.

Educational and volunteer programs that have addressed interests and needs of the elderly have varied according to local situations and resources. Below are some examples of Extension's programs:

NUTRITION

Delaware, home economist present nutrition programs monthly to 1,200 at the title VII nutrition sites.

Arizona received title IX funds to employ, train, and supervise elderly persons who teach nutrition and related areas to other older people.

Alaska developed slides, tapes and lessons on nutrition for use with senior citizens.

California conducts nutrition education programs at 13 title VII centers and retirement homes. One home economist serves as a consultant to the title VII program in Chinatown. She plans menus within Federal guildlines that are ethnically acceptable to 250 participants.

Connecticut conducted a series of four weight control programs for 40 senior citizens. Twenty-nine volunteers were trained to teach nutrition to 1,450 elderly citizens.

Florida trained 20 home health aides who work with the low income elderly and invalids.

Hawaii trained 111 volunteers (one-quarter of whom were men) to teach nutrition for older people, food supplements, meal planning and shopping. Estimated outreach was to 3,647 people.

Maryland. Eight volunteers taught nutrition lessons to 576 at nutrition sites.

HOUSING AND ENERGY

Mississippi. A home economist conducted a "how to wallpaper" workshop. One elderly woman did her own and saved $600, another $500, and one now wallpapers as a business.

Missouri conducted short courses on more suitable housing alternatives and home maintenance skills.

North Carolina received a grant to increase low income housing for senior citizens. In 9 months, 270 older people applied, 52 were completed and 7 were in process.

Ohio was funded by State commission on aging to conduct a pilot project to help the elderly in rural areas improve their homes at a reasonable cost. Workers were trained to make needed home repairs after house was surveyed.

South Carolina taught older people living in public housing simple basic home care skills and easy laundering techniques.

Texas presented educational programs to 1,200 older people on energy, simple home repairs and safety. An educational program resulted in 10 families receiving FmHA grants and 17 receiving loans.

Vermont. A home economist assisted senior center in preparing a grant for renovating the center which was approved.

Virginia. A home economist worked with senior center participants who remodeled and redecorated the senior center.

RESOURCE MANAGEMENT

In Arkansas conducted a legal affairs program for the elderly and as a result legal aide was made available to them and other low income families.

In Illinois, Extension cooperated with other agencies and conducted a "how, when, and where retirement show" that reached 30,000 senior citizens.

Maryland reached 300 people with educational program on wills and budgeting.

Mississippi reached 1,000 senior citizens with educational programs on frauds, cost of funerals, and better use of food dollar.

In Ohio five counties conducted programs on estate planning in cooperation with local lawyers, bankers, and insurance company representations.

In Texas, 3,600 participated in consumer education programs on wills, estate planning, keeping and recording important documents and dealing with frauds, 51 people participated in a program on income possibilities and investments.

Indiana reached 7,000 people at the nutrition sites with consumer choices and money management programs.

Indiana had 150 participants in a 10 week series on "coping with inflation."

HEALTH AND SAFETY EDUCATION

In Indiana, the home economist worked with the mental health agency and organized a widows group which meets a need and interest.

In Texas, 4,200 aging saved money and benefited from health screening clinics for diabetes, glaucoma, TB, hypertension, and anemia. Ten volunteers were trained to assist the elderly in filling out medicare forms.

In Virginia, 1,000 older adults participated in a blood pressure screening program.

In Delaware, a program on the prevention of falls was conducted at a senior citizen center.

A Florida home economist taught food safety practices to 45.

In North Carolina, 50 percent of the counties conducted safety programs for the elderly. "Elder abuse" was a statewide program on the prevention of mental and physical abuse.

INCOME PRODUCING

In Alabama 128 senior citizens learned how and made macrame purses as gifts and saved $4,000.

In Maryland, a group of women learned new skills in making and marketing quality crafts. The group paid for two trips with the $1,000 profit on crafts.

In Texas, 700 senior citizens received $14,628 from the sale of arts and crafts. A group of 40 senior citizens sponsored a talent fair and made $2,800.

In West Virginia, 45 quilters have been supervised by Extension staff and have earned $20,000 on the 30-month period.

4-H AND YOUTH PROGRAMS

Involvement of senior citizens in 4-H programs is continuing to increase throughout the country:

- —More senior citizens are becoming involved in 4H as volunteers—providing special expertise to 4-H members in their local clubs or through individual project work.
- —There are increased efforts to work with AARP and similar organizations to involve senior citizens in local 4-H programs and also in helping youth to understand problems of aging and what can be done to help the senior citizen.
- —Through 4-H community service projects, 4-H members are providing assistance to senior citizens in their homes or providing special programs for senior citizens in nursing homes and other institutions for the aged.

Some current examples of 4-H programs involving senior citizens include:

4-H has been working with the American Association of Retired Persons (AARP) for several years in developing the generations alliance program (an intergenerational understanding program). At present an evaluation of current programs where 4-H'ers and senior citizens are interacting, is being conducted by a 4-H intern in cooperation with AARP, procedures analyzed, accomplishments identified, and recommendations developed for future cooperative efforts.

In several New York counties, work is being done on intergenerational relationships through the generations alliance program of AARP and through heritage projects, e.g., written and oral recording of community history by youth interviewing senior citizens about community and personal activities in years past.

In Clay County, Ala., 4-H teenagers participated in a program to develop appreciation for senior citizens in the county as well as provide a service for them. Purpose was to help 4-H'ers gain a sense of empathy with the elderly, understand the aging process and other problems that arise through inter personal intergroup contact with senior citizens. Each member of the club agreed to adopt a grandparent for a 6-month period. During this time, he or she visited the person on a regular basis and assisted with small jobs, transportation and other needs of senior citizens. Results were very gratifying with both teenagers and senior citizens learning much from each other. Everyone involved thought the program was very successful and other counties plan to conduct similar activities this year.

Also in Alabama, 174 4-H members conducted foods and nutrition demonstrations for the elderly at the title VII nutrition sites. A similar program was reported in Des Moines County, Iowa. In Tama County, Iowa, 4-H cooperated with the schools and the food stamp distribution center to promote purchase of nutritious foods and improve the image of food stamps through a poster contest. Many of the recipients of this program were the elderly. Arkansas 4-H is continuing to have good results through their "4-H adopt a grandparent" program. Overall purpose of this program is to reestablish lines of communication between youth and senior citizens. Through this program, senior citizens have an opportunity to work closely with 4-H members on their projects, sharing their knowledge and experiences with 4-H members. 4-H members are not only benefiting by this sharing, but senior citizens are given a chance to feel useful and to regain feelings of self-worth.

Many State 4-H programs are utilizing the materials developed as a result of the 4-H and senior citizen volunteer project conducted by Texas in cooperation with Extension, USDA, special needs funds. A publication, "Seniors & Kids Involved in Learning Life's Skills" serves as a guide for county Extension agents on how to involve older adults in 4-H programs—outlining methods for initiating programs involving senior citizens, suggesting special considerations for working with older adults, offering guidelines for short-term 4-H projects, identifying needs of older adults that can be met by working as a volunteer in 4-H programs and at the same time identifying needs of youth that can be met through involvement with older adults.

A program called "Mountain Explo" in Jefferson County, Colo., organized cooperatively by Extension 4-H and the county's retired senior volunteer program has had good results. RSVP senior citizens join 4-H and Red Cross teen volunteers in leading younger children on 1-day summer camps designed to develop in children an awareness of and respect for their environment. Each child spends a full day with senior citizens in the mountain program. After receiving on-site training from park rangers, RSVP volunteers share their special knowledge—whether it be rocks or wild flowers. Mountain Explo fits right into the RSVP program since it enables volunteers to do something very worthwhile for the community. After the program's first year, the volunteers encouraged the 4-H staff to expand the program to include disadvantaged youth. In cooperation with schools, children with reading difficulties were selected for the second year of the program, involving an enrollment of 500. With schools providing transportation, cost for each child was minimal. The wildlife division of the Department of Education provided free study materials. Vocabulary lessons related directly to the environment.

4-H program assistants in Davidson County, N.C., have set up two reading rooms in low income housing developments and recruited retired teachers to staff them. Books and reading materials for this 4-H book program have been donated by various publishers. A film program was set up weekly during the summer months with the help of the county library. This program is reaching 100 youth per week with four volunteers and providing books to children who don't have them at home and are unable to go to the public library.

A Maryland 4-H program for the elderly, "project share" was developed in cooperation with the National Council on Aging, AARP, the University of Maryland Department of Agriculture and Extension Education, and the national 4-H council. This program is designed to bring about more successful interaction and greater sharing between the youth and elderly in selected Maryland communities. For example, an elderly man may teach a young man to play the guitar and in exchange the young man cuts his lawn.

In Kennebec County, Maine, county staff are cooperating with schools and churches on a geri-kid program in community nursing and boarding homes for the elderly. Primary goal is to provide opportunity for constructive exchange between young and old. To date, several hundred youths between the ages of 12 and 15 have participated. Youth serve a minimum of 3 hours per week as volunteers in the nursing and boarding homes. They are given a 12 to 15 hour training course before assuming such duties as assisting with feeding, reading, writing letters, exercise programs, activities programs, and rehabilitation activities. Kennebec County staff have worked closely with the nursing and boarding facilities in the development of the program and with the Kennebec 4–H Leaders' Association to help develop the program with Extension 4–H resources.

In Emery County, Utah, 4–H members conducted a project at the local nursing home. The project involved raising a vegetable garden near to the nursing home where patients had an opportunity to become involved in the garden if they chose. Many nursing home members took turns with 4–H members in caring for the garden. At the end of summer, vegetables were given to patients in the nursing home for their benefit and nutrition.

Members of the Cato 4–H Club (Mississippi) are involved in a program to adopt senior citizens in their community. They divide their club into four groups—each group including 4 to 6 youth and at least one senior 4–H member who is responsible for arranging transportation for the group and keeping dates for the senior citizens they have adopted. Each week after school or on week-ends, members of the 4–H Club visit their adopted friends and help with odd jobs about the home.

In another Mississippi County, a 4–H Club responded to a need for a meeting place for senior citizens. Cooperating with other community agencies, 4–H members cleaned and painted an old school building for a community center to be available for senior citizen programs as well as other community needs.

4–H members in Lenawee, Mich., helped with house repairs and odd jobs for senior citizens too infirm to do their own repairs. Similar efforts are being done by 4–H members throughout the country.

FARMERS HOME ADMINISTRATION (FMHA) SECTIONS 502 AND 504 RH LOANS

The Farmers Home Administration has two rural housing loan programs available to elderly who live in rural areas.

Section 504 rural housing loans are available to qualified low-income applicants to make basic repairs necessary to remove health and safety hazards. This includes such items as roof repair, storm windows, and doors, insulation, water systems, and waste disposal systems. The maximum loan is $5,000 and the interest rate is 1 percent. For the fiscal year 1979 $24 million is available for 504 loans. For elderly applicants who do not have repayment ability for a 1 percent loan, grant funds may be available for necessary improvements. Nineteen million dollars are available in fiscal year 1979 for the grant program. This compares with $9 million available in 1978.

Elderly applicants may also be assisted under the section 502 loan program. Such loans are available to build, purchase or rehabilitate modest homes that are adequate to fit the needs of the applicant. The interest rate on section 502 loans is currently 8.75 percent, with a maximum repayment period of 33 years. For low-income applicants, reduced interest rates are available to as low as 1 percent depending on income, number of people in the household, amount of loan installment, real estate taxes, and property insurance. Seventy percent of the $2.867 billion available for section 502 loans in fiscal year 1979 is allocated to applicants who will qualify for the reduced interest rates.

Farmers Home Administration regulations are currently in process of revision. Under consideration is a provision to allow for adequate space to include elderly family members, such as parents or grandparents, as a part of the household.

RURAL RENTAL HOUSING

The section 515 rural rental program provided 34,300 units for $676 million in loan obligation during fiscal year 1978. Of these, approximately 30 percent were for the elderly. Many of these units were subsidized with FmHA rental assistance or the Department of Housing and Urban Development (HUD), Section 8 assistance payments. Under these programs, low-income elderly households are required to pay up to 25 percent of their income for rent, including utilities. If their income is too low to enable them to pay the market rent, these subsidies make up the difference.

For fiscal year 1979, FmHA has budgeted $868 million for rural rental housing and $425.5 million for rental assistance. FmHA has also received from HUD $10,000 units of Section 8 set-aside to be used with the rental housing program. The FmHA State directors are working on a State by State basis with their HUD counterparts to determine the ratio of elderly units to family and large family units subsidized by section 8 assistance.

ADVOCACY

FmHA has assumed a leadership role in advocating for improved services for the rural elderly. A staff position has been designed with this objective as its primary function. Some of these advocacy efforts include the following:

(1) Testimony presented on behalf of the rural elderly by the Assistant Secretary for Rural Development at the oversight hearings on the Older American Act.

Several of the recommendations made were incorporated into the new amendments. For example, it was suggested that a study be conducted to examine the inaccessibility of services as well as increased costs of delivering services to the rural elderly. The Federal Council on Aging has been asked to conduct such a study. It was also recommended that additional support be provided for model and demonstration efforts that offer alternatives in reaching the elderly outside the cities.

(2) Dissemination of information to congressional members and staff persons with concern for the aged.

FmHA provided data on the rural urban differences in service delivery which impacts on the quality of life for the rural elderly. FmHA's efforts were cited by Senator Domenici and contributed to the mandate by the Administration on Aging that State agencies on aging spend additional funds in rural counties of the States.

(3) National Strategy Meeting on Rural Aging.

The Farmers Home Administration sponsored a national strategy meeting on rural aging which was held in Des Moines, Iowa, January 29–February 2, 1979. The purpose of the meeting was to bring together persons from the field who have expertise in rural aging and related areas to develop sound recommendations and alternatives to improve the quality of life for the rural elderly. The meeting was convened by the Iowa Lakes Area Agency on Aging, the grantee, and the National Association on Area Agencies on Aging. One of the outcomes of the meeting was the adoption of a resolution to form an ad hoc coalition on rural aging to bring the problems of the rural elderly to the attention of executive agencies, congressional members, and the White House. It is expected that the coalition will play a major role in the implementation of the recommendations made at the national meeting and will also have a substantial role at the 1981 White House Conference on Aging.

The Farmers Home Administration has assumed the leadership role at the Federal level for bringing national attention to the special problems of this target group. Our efforts have received the support of other agencies, the White House, and the Congress as evidenced by the attendance and participation at the meeting of executive branch agencies, congressional members, and staff representation from the White House. This is the first national meeting with primary concern for the elderly who reside outside the cities.

FOOD AND NUTRITION SERVICE

JANUARY 2[illegible], 1979.

DEAR SENATOR CHILES: This is in response to your December 1, 1978, letter to Secretary Bergland. We are enclosing two copies each of summaries on food assistance programs directly related to the elderly. The food stamp and food distribution programs are administered by the Food and Nutrition Service and afford specific benefits to our senior citizens in several ways. These summaries outline those methods.

ROBERT GREENSTEIN,
Acting Administrator.

Enclosures.

FOOD STAMP PROGRAM

Primary among the concerns of Congress, the Department, State, and local program administrators, and community groups is the low participation of the elderly in the food stamp program. Many believe the elderly have substantial problems which prohibit them from participating in the program. The problems include lack of transportation, complex and confusing program rules, and restrictive income and resource limitations. In addition, the welfare stigma is considered by many to deter program participation. According to the most recent survey conducted by the Department in September 1976, there are 996,000 elderly persons (age 65 and over) in the food stamp program. Because of the concern expressed by so many, Congress included several provisions in the Food Stamp Act of 1977 to raise the low participation of the elderly, which is between 40 and 50 percent of the total number eligible to participate in the food stamp program.

The first major program change has been accomplished. The purchase requirement, widely attacked as a barrier to food stamp participation, was eliminated on January 1, 1979. As the new Food stamp program is implemented, the following changes will be made: First, the exemption age for work registration will be lowered from 65 to 60 years. Second, a 12-month certification period can be assigned to households consisting entirely of elderly, as well as unemployable or self-employed, persons. Third, the use of authorized representatives during the certification process will be encouraged. Fourth, mail service, telephone interviews, and/or home visits will be used to certify those persons who, because of age, disability, or transportation problems, are unable to reach a certification office. And, fifth, the resource limit will be raised from $1,500 to $1,750 per household. This includes households made up of only one person. This increase in allowable resources should be a tremendous asset to the elderly as 63.7 percent of all elderly reside alone according to the Department's 1976 household characteristics survey. (The resource limit remains at $3,000 for households of two or more people when at least one person is over 60 years old.) On the other hand, the new law removes categorical eligibility, therefore, supplemental security income (SSI) participants will be required to satisfy the same eligibility standards as all other food stamp participants. Regulations implementing these provisions were published in the Federal Register on October 17, 1978. As a result of this final rulemaking, all States must begin implementing the new eligibility and benefit determination rules no later than March 1, 1979.

The Food Stamp Act of 1977 also provides that SSI applicants and participants be permitted to apply for food stamps at the social security office in conjunction with their application for SSI benefits. Regulations for implementing this requirement are being developed with the Department of Health, Education and Welfare and will be published in the Federal Register as proposed rulemaking for public comment at a later date.

Further, under the 1977 Food Stamp Act, the Department is authorized to conduct various demonstration projects, one of which involves the payment of cash rather than food coupons to households consisting either entirely of members who are 65 years old or members entitled to SSI benefits. The project is a response to the belief that the low program participation rate among this target population is due to the welfare stigma these households associate with the use of in-kind benefits such as food stamps. The project will test the feasibility of providing cash in lieu of food coupons to these households as a means of improving the participation of and service to these households.

The cash-out project will be conducted in 14 project sites chosen from among the seven FNS administrative regions and will be operational for a period of 1 year. Project operations are scheduled to begin during August of this year. Proposed regulations, which will govern the operation of the project, and a notice of intent, which will solicit the participation of State welfare agencies in the demonstration project, are in the final stages of preparation. The results of the study will be forwarded to Congress for consideration in determining the feasibility of implementing the cash-out procedure for handicapped and elderly households on a nationwide basis.

Under this same authority, the Department is currently conducting a demonstration project in California, the SSI conversion project. The project was undertaken in September 1978 to avert a potential crisis resulting from the loss of the State's cash-out status.

Under the project, SSI households are certified as separate households and provided the appropriate food stamp allotments. Certification of and issuance to SSI household members are automated by applying the new income and benefit computation formulas to SSI stored data, and direct mailing of benefits to households from centralized State-run location.

The conversion project was initially scheduled to operate for 10 months. However, the recent passage of P.L. 95-458 (the Corman-Cranston Bill, H.R. 1337), which amends P.L. 93-233 to reinstate California's cash-out status, officially terminates the SSI conversion project on February 1, 1979. The California

3-41

Department of Social Services will be conducting an evaluation to determine the applicability of the project procedures in other locales.

The Food Stamp Act of 1977 and the food stamp program regulations published September 22, 1978 include other provisions to assist the elderly and the handicapped. The law and regulations provide for the use of food stamps by participants age 60 and over and their spouses to purchase meals from certain public and private communal dining facilities. Communal dining facilities which are eligible for authorization to accept food coupons include senior citizen's centers, apartment buildings occupied primarily by elderly persons or SSI recipients and the spouses, public or private nonprofit establishments (eating or otherwise) that feed elderly persons or SSI recipients and their spouses, and federally subsidized housing for the elderly at which meals are prepared for and served to the residents, and any other public or nonprofit private establishment approved for such purpose by the Department.

In addition to the facilities listed above, private establishments which have contracts with State or local agencies to prepare and serve (or deliver) low-cost meals to elderly persons and SSI recipients (and, in the case of meal delivery services, to elderly persons or handicapped persons) and their spouses during regular or special hours may be authorized to accept food coupons. Therefore, the only private facilities which will be considered for authorization to participate in the food stamp program are those that are nonprofit or that have a contract with a State or local agency.

As of September 30, 1978, there were 1,973 nonprofit meal delivery services, 6,063 nonprofit communal dining facilities and 568 commercial dining facilities (restaurants) for the elderly.

In closing, outreach will continue to play a major part in the food stamp program. There is a clear need for accurate information about the program to be disseminated to low-income families. This is especially true because the Food Stamp Act of 1977 drastically changes eligibility requirements and procedures. Elderly persons as well as any low-income individual should be informed about how the "new" program will work. To accomplish this goal, States are informing the public about the changes mandated by the new Act, particularly EPR and the new financial eligibility criteria. At the end of this period of transitional outreach, the States will resume their ongoing outreach efforts. The Department is currently developing revised instructions covering ongoing outreach, i.e., informing low-income households of the availability and benefits of the food stamp program. The guidelines will be based on previous experience in conducting outreach and on the Food Stamp Act of 1977.

In our plans for 1979, careful consideration will continue to be given to the situation of senior citizens.

FOOD DISTRIBUTION PROGRAM

An amendment to title VII of the Older Americans Act of 1965, Public Law 93-351, enacted July 12, 1974, had a significant impact on USDA food donations to nutrition programs for the elderly funded under the act by the Department of Health, Education, and Welfare. This legislation set the minimum level of donated food assistance to these programs at 10 cents per meal (subject to annual adjustments for increased food service costs) and required USDA to give emphasis to purchasing high protein foods, meat, and meat alternates.

Subsequently, Public Law 94-135, enacted November 27, 1975, amended the Older Americans Act to expand the food donation authority to maintain an annually programed level of food assistance to title VII projects of not less than 15 cents per meal in the fiscal year ending on September 30, 1976, and not less than 25 cents per meal for the fiscal year ending on September 30, 1977. Applying the annual adjustment for increased food costs, this resulted in 16½ cents per meal for fiscal year 1976 and 27¼ cents per meal for fiscal year 1977. This legislation further provided, ". . . in any case in which a State has phased out its commodity distribution facilities before June 30, 1974, such State may, for purposes of the program authorized by this act, elect to receive cash payments in lieu of donated foods . . ." Kansas was the only State eligible to qualify under this provision. However, Public Law 95-65 enacted on July 11, 1977 extended the option for cash payments in lieu of donated foods to all States without regard to the termination of State food distribution facilities. With the programmed level of assistance at 29¼ cents a meal in fiscal year 1978, 21 States elected to receive their entitlement in all cash payments; 18 elected to receive only donated foods: whereas 17 States requested a combination of the two. In fiscal year 1978, approximately $18½ million in donated foods and over $22 million in cash payments were provided to some 1,000 elderly feeding projects with over 10,000 sites serving an estimated 130.4 million meals in fiscal year 1978.

With the enactment of Public Law 95-478 on October 18, 1978, social service functions and the title VII congregate feeding program were integrated under an expanded title III. In addition to the consolidation of services under this title, emphasis was included in the law to provide meal delivery services to the home bound elderly along with the continuation of congregate feeding. Both of these meal services are eligible for food donations or cash-in-lieu payments at the new legislated level of 30 cents a meal for fiscal year 1979, 1980, and 1981 as adjusted annually in the food-away-from-home series of the Bureau of Labor Statistics. Based on this adjustment, food donations or cash-in-lieu payments are being provided on the basis of 38½ cents a meal in fiscal year 1979.

Aside from elderly feeding programs administered by the Administration on Aging, USDA makes a limited variety of foods obtained through price-support activities available to public or private charitable institutions which may be serving senior citizens. Among the institutions which are eligible to receive food to the extent of the number of needy persons served, are nursing homes, senior citizens centers and meals on wheels programs. In fiscal year 1978, there were over 7,000 institutions receiving food donations for an estimated 800,000 needy persons.

ITEM 2. DEPARTMENT OF COMMERCE

JANUARY 29, 1979.

DEAR MR. CHAIRMAN: The enclosed report summarizes the Department of Commerce activities during 1978 related to the aging. I trust the information will be useful to the Senate Special Committee on Aging and other organizations or persons concerned with the elderly.

With warm regards,
Sincerely,

JUANITA M. KREPS.

Enclosure.

PROGRAMS FOR THE AGING—1978

STATISTICAL RESEARCH, DATA, AND REPORTS

The following reports were issued by the Bureau of the Census in its "Current Population Reports" and other publication series during 1978. The reports contain information about the demographic and socioeconomic characteristics of the population. Many of the "Current Population Reports" will be updated in 1979.

Current Population Reports

Series P-20

No.	*Title*
314	Educational Attainment: March 1976 and 1977.
322	Voting and Registration in the Election of November 1976.
323	Marital Status and Living Arrangements: March 1977.
324	Population Profile of the United States: 1977.
326	Household and Family Characteristics: March 1977.
327	Households and Family by Type: March 1978 (Advance Report).
328	Persons of Spanish Origin in the United States: March 1978 (Advance Report).
329	Persons of Spanish Origin in the United States: March 1977.
331	Geographic Mobility: March 1975 to March 1978.

Series P-23

No.	*Title*
64	The Geographic Mobility of Americans: An International Comparison.
69	1976 Survey of Institutionalized Persons: A Study of Persons Receiving Long-Term Care.
75	Social and Economic Characteristics of the Metropolitan and Nonmetropolitan Population: 1977 and 1970.

Current Population Reports—Continued

Series P–25

No.	*Title*
721	Estimates of the Population of the United States by Age, Sex, and Race: 1970–1977.
734	Estimates of the Population of States, by Age: July 1, 1971 to 1977.

Series P–27

No.	*Title*
51	Farm Population of the United States: 1977.

Series P–60

No.	*Title*
109	Household Money Income in 1976 and Selected Social and Economic Characteristics of Households.
110	Money Income and Poverty Status in 1975 of Families and Persons in the United States and the Northeast Region, by Divisions and States (Spring 1976 Survey of Income and Education).
111	Money Income and Poverty Status in 1975 of Families and Persons in the United States and the North Central Region, by Divisions and States (Spring 1976 Survey of Income and Education).
112	Money Income and Poverty Status in 1975 of Families and Persons in the United States and the South Region, by Divisions and States (Spring 1976 Survey of Income and Education).
113	Money Income and Poverty Status in 1975 of Families and Persons in the United States of Income and Education).
114	Money Income of 1976 of Families and Persons in the United States.
115	Characteristics of the Population Below Poverty Level: 1976.
116	Money Income and Poverty Status of Families and Persons in the United States: 1977.

Current Housing Reports

Series H–150–76

Annual housing survey:

Part A.—General Housing Characteristics for the United States and Regions: 1976.

Part C.—Financial Characteristics of the Housing Inventory for the United States and Regions.

Part D.—Housing Characteristics of Recent Movers for the United States and Regions.

Part E.—Urban and Rural Housing Characteristics for the United States and Regions.

Other Reports

Special reports and papers prepared by the Census Bureau include the following:

Geographical Patterns in Selected Aspects of the Living Arrangements of the Elderly: 1970 Census Data for States, HEW Regions, and the United States.

A Microsimulation Approach to Mortality and Aging for Population Projection.

Recent and Prospective Demographic Trends for the Elderly Population and Some Implications for Health Care.

Demographic Background for International Gerontological Studies.

In addition to the foregoing, a member of the Census Bureau's population analysis staff provided testimony at a joint hearing of the Select Committee on Population and the Select Committee on Aging, U.S. House of Representatives. The topic was "Prospective Trends in the Size and Structure of the Elderly Population, Impact of Mortality Trends and Some Implications." Written responses were provided to questions from members of the Joint Committee.

The National Technical Information Service (NTIS) sells the technical report "The Elderly" (Social Health and Transportation Problems and Services), Volume I, NTIS–PS 77/0672; and Volume II, NTIS–PS 77/0673. The report primarily treats topics on social services, health, housing, and transportation problems.

Another NTIS report, "Transportation for the Elderly or Physically Handicapped," NTIS–PS 77/0713, contains abstracts of reports on transportation difficulties and designs as they relate to the aged and handicapped population. The source documents were submitted to NTIS by both Federal and non-Federal organizations.

BUSINESS ASSISTANCE

District Offices of the Bureau of Field Operations, Industry and Trade Administration, have been assisted by the Service Corps of Retired Executives (SCORE). One of the primary missions of the district offices is to provide technical business assistance to private companies. Lack of sufficient resources, however, has often limited the amount of help the Offices could provide. With the help of SCORE personnel, who were given detailed business information, an expanded assistance program has been possible. SCORE has participated in such activities as seminars on international export promotion and the development of business plans.

The district offices also maintain contacts with the various state departments of labor and industry. One reason for this continuing contact is to provide the public with information that would be helpful in the establishment or expansion of small firms. Special attention is given the elderly.

SAFETY

The Center for Fire Research of the National Bureau of Standards is conducting a research program that will benefit the aging. It is:

To develop life safety systems for the type of buildings frequently used by the elderly; e.g., hospitals, nursing homes, and other institutional facilities. The program is focusing on six elements of life safety: (1) Decision analysis; (2) behavior in fire emergencies; (3) alarm and communication systems; (4) smoke control systems; (5) fire and smoke detectors; and (6) automatic extinguishment. This work is supported by and done in conjunction with the Department of Health, Education, and Welfare and has been underway since 1975.

The United States Fire Administration (USFA) continued a research project on fire prevention methods and standards for nursing homes and hospitals. The project began in 1976 and is expected to continue through 1979.

A second USFA project which continued throughout 1978 was a public education program directed toward fire prevention among the elderly, who have the highest rate of injury and death from fire. The program couples written materials with radio and TV spots.

During 1978 USFA implemented a nationwide program to include the elderly in fire prevention home inspections conducted by local fire departments.

The National Weather Service of the National Oceanic and Atmospheric Administration (NOAA) publishes daily weather forecasts which are very useful to all citizens. Specifically, this information is extremely important to the elderly. The forecasts of severe storms, extreme heat, pollution index, floods, tornadoes, and hurricanes provide advance information which helps less mobile older citizens plan and act on ways to avoid predicted weather which could cause a crisis. For long range planning, NOAA's Environmental Data Service (EDS) makes information available concerning weather trends in various regions of the country.

PATENTS

The Patent and Trademark Office continued the procedure that permits patent applications from applicants who are 65 years of age or older to be "made special." This procedure allows the patent application to be taken up for examination earlier than its effective filing date would normally permit (Section 708.02, Manual of Patent Examining).

Patents issued on some compositions or devices having a useful or beneficial effect on diseases or other medical problems have a greater impact on the aging than on the general population. Patents in this category which were issued during 1978 are the following:

No. 4,070,483	Method of administering a human ocular treating agent and product thereof.
No. 4,071,293	Contact lens and method of making same (Bifocal lens).
No. 4,071,629	Novel pharmaceutical compositions and method for treating psychasthenia (a state of neurosis manifested by fear, anxiety, or a feeling of strangeness).
No. 4,073,578	Spectacle lens for aphakia (absence of lens of eye) patients.

No. 4,085,218	Elevating mood in Geriatric patients.
No. 4,088,778	Method for the treatment of hypertension.
No. 4,095,878	Soft contact lens with flattened region for automatic orientation.
No. 4,096,254	Method of treating the symptoms of menopause and osteoporosis (degeneration of bone due to mineral loss).

HEALTH AND RECREATION

For almost 50 years the National Bureau of Standards (NBS) has maintained the national standards for measurement of exposure of people to X-rays and gamma rays for medical purposes. This includes diagnostic procedures to detect problems such as cancerous growths, and therapeutic procedures to attempt cures of the problems. As people grow older, the probability of diseases which require such procedures increases.

A similar situation exists with regard to the use of radiopharmaceuticals, which are radioactive materials applied internally to the human body, primarily for diagnostic procedures. Since these procedures are used for a variety of illnesses, they are applied to approximately one-fourth of hospital patients. Again, since older people have more illnesses, they make more use of these services. NBS routinely provides samples of radiopharmaceuticals which are used as measurement standards so that a safe, but effective, amount can be administered to the patient.

The NBS Center for Consumer Product Technology initiated a study on blood pressure measuring devices, which are vital to the aging. The study will assess and compare the differences in detection criteria as employed by electronic sphygmomanometers and medical professionals.

Another NBS project relates to the accurate and precise compositional analysis of body tissue and fluids, which is essential to optimal health care for the aged since it provides a physician or surgeon with the information necessary for making better diagnostic and treatment decisions. Because of the poor accuracy inherent in many chemical methods used by clinical laboratories, discrepant results are obtained. This can confuse the physician and sometimes cause an erroneous diagnosis. Laboratory tests must often be repeated because of discrepant results. This places a significant financial burden on elderly patients since charges for these retests must also be made. In order to improve the accuracy of clinical laboratory measurements and therefore the comparability between laboratories throughout the U.S., the NBS is actively involved in research and development efforts which lead to: (1) New and/or improved methodology which can be used by these laboratories, and (2) standard reference materials such as cholesterol, urea, glucose and serum albumin have made a profound impact in the diagnosis of heart disease, gout, and arthritis, diabetes and serum protein, respectively.

NBS also has on-going research and development efforts which are helping this Nation meet its goal of protecting and enhancing the quality of the environment so as to promote the public health and welfare of its population. For example, the detection of undesirable impurities in the nation's water and air resources can have profound impact on consumer health. Many forms of disease or illness could result, especially to the elderly, from "contaminated" environment. Major contributions have been made by NBS in the environmental monitoring area. There is increased demand for NBS to continue and improve the accuracy and precision of compositional analysis in health, environment, and industry so that citizens, particularly the aged, can live in a healthy environment and receive optimal health care.

At the National Oceanic and Atmospheric Administration both the National Marine Fisheries Service (NMFS) and the National Ocean Survey (NOS) provide information that can be of importance to those retired citizens who wish to take part in marine recreational activities such as fishing and boating. Such information is supplied through recreation guides, charts, and other publications. Another NMFS publication is a monthly guideline pertaining to the "best buys" on fish for each geographic region. This informs the elderly of less expensive ways to fill their diet with high protein food.

ITEM 3. DEPARTMENT OF DEFENSE

January 18, 1979.

Dear Mr. Chairman: This is in reply to your letter of December 1, 1978, requesting information on Department of Defense actions and programs related to aging.

The Department of Defense continues to operate one of the most comprehensive retirement planning programs for civilian employees in the Federal Government. Integrated into the overall personnel management process, our program is designed to assist employees in their adjustment to retirement and to assist management in planning for replacement manpower needs. Retirement planning programs make it plain that employees are not being pressured to retire. These programs offer counseling for employees (and in many instances their spouses) on such subjects as financial planning, health needs, leisure time activities, living arrangements, and personal guidance. Included is a program of trial retirement and gradual retirement options for employees where feasible. We believe our program helps alleviate many of the problems that employees have encountered in the past when approaching retirement age. We expect to continue the operation of this program through 1979.

The military departments and Defense agencies, in cooperation with community health officials, have continued to provide multiphasic occupational health programs and services to employees, and in some cases, to former employees who have retired. Many of these programs and services are designed to address problems generally associated with increasing age. Included are health guidance and counseling, periodic testing for diseases and disorders, immunizations, and treatments. We plan to continue to provide these services to employees to the maximum possible during 1979.

W[illegible] the Department active and continuing efforts are conducted to eliminate discrimination based on age. Such efforts include the deletion of date of birth from career records and the elimination of age criteria for training courses and incentive awards. There is also carried out a continuing examination of personnel regulations to assure that age is not used as a selection criterion or screening factor in other personnel actions and that policies, practices, and procedures are not in conflict with the goal of equal employment opportunity.

The Department of Air Force has instituted a management employee communications program to stress positive employment factors such as job challenge and opportunity for advancement which includes the information that older employees are to be encouraged to pursue a career path of their choosing. That agency is optimistic that emphasis on positive employment factors and less emphasis on retirement will prove beneficial by reducing the high cost related to attrition.

In summary, the Department of Defense operates a comprehensive retirement planning program for civilian employees, provides extensive health care services to employees, and carries out an on-going, affirmative action program to preclude discrimination based on age. These program efforts will be continued in 1979.

Sincerely,

Carl W. Clewlow,
Deputy Assistant Secretary of Defense
(Civilian Personnel Policy).

ITEM 4. DEPARTMENT OF ENERGY

February 9, 1979.

Dear Mr. Chairman: In response to your request of December 14, 1978, to Secretary Schlesinger, we are pleased to summarize major Department of Energy (DOE) activities in 1978 which affected the aging. DOE's efforts in 1978 spanned five broad categories: Policy initiatives; programs directly involving service for or by the elderly; data initiatives; public participation; and biological research on aging.

Before reviewing DOE efforts in these specific areas, it should be stressed that a wide-range of Departmental programs and policies have as their immediate or long-term objective the assurance of adequate, reasonably priced energy supplies. The achievement of these goals is, of course, critical to the Nation as a whole, but is particularly urgent for senior citizens and disadvantaged Americans whose resources are strained by energy and energy related impacts on the economy. Energy conservation, increased production of domestic fuels in lieu of more expensive and insecure imports, utility rate reform, the development of renewable resources, energy development impact assistance efforts, incentives through tax credits and many other aspects of energy policy have significant implications for older citizens. The following specific programs and activities are of particular relevance:

POLICY INITIATIVES

The Department's single highest priority in 1978 was to assist the Congress in deliberations which resulted in passage of the National Energy Act. With passage of the act, the Department is now responsible for implementing most of its major provisions. Several aspects of the act will have major impacts on the senior citizens of this Nation and the Department will strive to make sure those impacts upon the aging are both positive and equitable Those new provisions which will most immediately affect senior citizens are:

(1) Utility rate reform activities in each State will encourage each public service commission to address the equity of rate structures and certain regulatory practices. The standard regarding termination of utility service and the required consideration of lifeline rates directly affect senior citizens. The Administrator of the Economic Regulatory Administration addressed the hardship of service termination by writing each State regulatory authority and urging early consideration of this regulatory standard before the 1978–1979 heating season.

(2) Tax credits for conservation and solar home improvements (senior citizens are the largest single population subgroup which own their own homes).

(3) Federal support of loans for conservation and solar home improvements with priority given to the elderly and moderate income families.

PROGRAMS IMPACTING THE ELDERLY

Several DOE operating programs have direct or indirect impact on the aging:

(1) *Weatherization program.*—In 1978, the weatherization assistance program awarded over $64 million in grants to States and 24 Native American tribal organizations for weatherizing homes of low-income persons, particularly elderly and handicapped low-income persons. Reports for the quarter ended September 30, 1978, indicate that 72,500 low-income homes were weatherized and that the majority of those dwellings were occupied by the elderly.

(2) *The appropriate technology small grants program.*—This program which is intended to provide small grants to individuals, small businesses, local nonprofit organizations for developing community energy technology or techniques can benefit the aging. For instance, the Yavapac Council for the Aging in Prescott, Ariz., has developed a solar hot water project. Region VII (Kansas City), using another approach, is negotiating with their local Service Corps of Retired Executives (SCORE) to provide the technical feasibility review of AT grant proposals submitted to that region.

(3) *Other grant programs.*—Grants to nursing homes and hospitals to accelerate conservation in those institutions, should indirectly assist senior citizen users of those public institutions, by curbing somewhat the rapidly rising energy costs of operating those institutions.

The DOE grant program to State offices of consumer services has, in several States provided pass through funding to senior citizen organizations wishing to represent the aging in State utility rate proceedings.

(4) *Publications.*—Indirect benefits to senior citizen users of health care facilities may occur as health facility administrators voluntarily use four specialized DOE health publications. They are: "Total Energy Management for Hospitals," "Total Energy Management for Nursing Homes," "Identification of Energy Issues in Health Care," and "Literature Search for Energy Issues in Health Care."

The DOE publication "Winter Survival," although useful for persons of all ages, has been requested in particularly large numbers by groups representing the elderly. For example, the Ohio Commission on Aging alone has distributed 4,000 copies to senior citizens. During 1978, 750,000 copies of this booklet were distributed and another 500,000 copies have been made available for the winter of 1979.

DATA INITIATIVES

The Energy Information Administration has identified two analysis activities undertaken in 1978 which might be of interest. These are: a human resources data system and an analysis of projected household energy expenditures in 1985.

The computer model, "Micro Analysis Transfers to Household/Comprehensive Human Resources Data System (MATH/CHRDS)" arrays data for analyzing the expenditure impact on elderly households (and those of other population subgroups) of changing national energy prices and other broad energy policy directions. The model can assess impacts of future energy trends and policies across many socioeconomic variables such as age, race, sex, income, and location. It also describes ways in which important energy related household characteristics may change over time in response to economic, demographic, and energy changes. MATH/CHRDS was used as a fully operational computer model for the first time in 1978.

A key report analyzing household energy expenditures—including expenditures by the elderly—was prepared by EIA in 1978, based upon the Human Resource Data System. Titled, "A Distributional Analysis of 1985 Energy Projections for the Annual Report to Congress of the Energy Information Administration" (Pub. No. DOE/EIA-0102/18), this report provided data for 1974 and projections for 1985 on household energy expenditures. Data and projections include: average dollar amount of household energy expenditures; expenditures as a percentage of disposable income; and average household expenditures as a percentage of disposable income for all fuels, all home fuels, and gasoline.

PUBLIC PARTICIPATION ACTIVITIES

At the regional level of DOE special outreach activity occurred to improve senior citizen access to energy information. Summaries of regional efforts are appended as enclosure 1 to this report.

Substantive citizen, including senior citizen, input into key national public participation processes such as the domestic policy review of solar energy and the intergovernmental review of nuclear waste management has been excellent. However, the Department will try to increase participation by senior citizens or their representatives during 1979 National Energy Act public hearings through special outreach specifically targeted to them.

Finally, DOE has worked closely with the National Energy Coordinator of SCORE to facilitate delivery of energy information and assistance to the American small business community.

RESEARCH RELATED TO BIOLOGICAL AGING

The Department of Energy field laboratories conducted two categories of studies related to biological aging during 1978. Those categories were:

(1) Studies that produce data on physiologic and pathologic changes occurring in aging human and animal populations; and

(2) Studies directly concerned with clarifying the biological basis of aging.

A complete description of these research activities is appended as enclosure 2.

We are pleased to contribute to your annual review of Federal actions and programs related to aging.

Sincerely,

PHILLIP S. HUGHES, *Assistant Secretary,*
Intergovernmental and Institutional Relations.

Enclosures.

Enclosure 1

REGIONAL ACTIVITIES RELATED TO THE AGED DURING 1978

REGION I

The Administration on Aging shares membership on the New England Energy Task Force Consumer Impact Task Group (chaired by DOE) with other Federal agencies responsible for energy related services. For the fourth year this task group has published a "Guide to Federal Consumer Energy Assistance." Region I is also serving as a resource to the New Hampshire Forums on Energy and the Aging.

REGION II

DOE participated in two HEW consultation clinics for agencies and persons concerned with services to the elderly. Ongoing information services for elderly and other consumers included referrals for crisis intervention funding, weatherization, and energy saving/comfort tips.

REGION III

Energy saving information is distributed widely and regularly to social service agencies throughout the region, many of which serve the needs of elderly citizens. In addition, the region has conducted energy awareness day programs for the benefit of senior citizen groups and others and has engaged in efforts to assist elderly consumers to find help in cases of fuel interruptions and difficulty in meeting utility costs. Approximately 90 percent of the recipients of weatherization assistance in the region have been elderly citizens.

REGION IV

An exhibit and DOE publications were provided at the Tennessee Department of Aging, Governor's Conference on Aging. As a member of the Community Involvement Committee Task Force of the Federal Executive Board, the region helped to develop a tracking system illustrating how people in the seven-county Metro Atlanta area are affected by Federal income maintenance funds. Energy saving publications were provided to the Library of Congress; as a result of this effort, energy information is now available in large print, braille, and records for elderly and other vision impaired consumers.

REGION VI

Elderly and other consumers requesting weatherization or emergency energy assistance were provided information or referred to other agencies. The Federal Executive Board Committee on Consumer Affairs did a series of radio spots on Energy and other subjects of concern to the elderly in the Dallas-Fort Worth area.

REGION VII

DOE conducted three separate energy conservation presentations for the American Association of Retired Persons. Emphasis was placed on inviting low-income and elderly persons to testify at weatherization program public hearings.

REGION VIII

The Mountain Plains Congress of Senior Organizations was consulted by the region during production of a four-part consumer television series to make certain that interests and problems of the aging were included and addressed in the series. Development of a technical and information program for organizations representing the aging in utility rate reform was begun. Special efforts were made to include representatives of aging groups on hearing panels.

REGION IX

On-site workshops were held for senior citizens in Tucson and Phoenix, Ariz., in cooperation with local community action agencies. Similar activities were conducted in Nevada and California. Region speakers addressed senior citizen groups on energy conservation throughout the Region; large quantities of educational materials were also mailed to senior citizen groups. Workshops were held to assist social workers and CAP personnel in dealing with the energy problems of the elderly. As a member of the Community Services Administration finding committee, the region assisted in deciding allocation of emergency funds to senior citizens.

REGION X

High priority was placed on reviewing State weatherization plans to ensure adequate senior citizen service by the grantee. Nearly a fourth of potential applicants for the appropriate technology small grants program that the region personally assisted were elderly. Assistance to these elderly respondents included advice on engineering feasibility and contacts with other private and government sources who might be interested in proposals. An active referral of senior citizen callers to agencies or utilities responsible for handling specific energy problems was provided as a service. The Washington State local chapters of the Retired Teachers Association regularly called on Regional staff as speakers. In addition to circulating insulating and weatherization pamphlets, the region also expanded the number of senior citizen groups or service agencies on its outreach mailing list.

Enclosure 2

RESEARCH RELATED TO BIOLOGICAL AGING

As in previous years, the Office of Health and Environmental Research (OHER) has administered a major program of research aimed at identifying and characterizing health impacts of the energy-producing technologies. In assessing energy related health impacts, it is particularly important to determine long-term and late-appearing health effects induced by chronic exposures to low levels of hazardous chemical or physical agents. Since health effects induced by chronic low-level exposures to toxic agents typically develop progressively over the entire life span or a significant fraction thereof, it is essential that such effects be clearly differentiated from functional decrements, morbidity patterns, and mortality that occur as a result of the aging process. To make a statistically valid differentiation between induced health effects and spontaneously occurring aging effects, detailed information on pathophysiologic changes occurring throughout the life span must be collected for both exposed and unexposed (control) populations of adequate size. Pathophysiologic data are collected from human populations whenever possible but primarily from controlled studies of animal populations. Studies conducted in this manner inevitably generate data describing age-related changes that occur in unexposed populations and in populations exposed to specific toxicants. Such data not only help to characterize the aging process but also define how sensitivity to hazardous agents may change with age. Given the importance of biological aging in the study of late-appearing health effects, additional studies are conducted in order to obtain a better understanding of the aging process itself. Thus, although the Department of Energy does not sponsor an organized program of research on the aging process, two categories of studies related to biological aging were conducted during 1978: (a) studies not directly concerned with biological aging but that produce data on physiologic and pathologic changes occurring in aging human and animal populations, and (b) studies directly concerned with elucidating the biological basis of aging.

Lifetime studies of human and animal populations constitute the major effort in the ongoing program of research related to biological aging. Because of an extensive and long-term involvement in lifetime animal studies, several Department of Energy laboratories are contributing information to the laboratory animal data bank that is being developed by the Battelle Columbus Laboratories under support from the National Library of Medicine and other Federal health agencies. The Department of Energy laboratories are providing data on life histories, pathology, hematology, and clinical chemistry obtained from control (unexposed) animals, both long-lived and short-lived, used in long-term studies. Five research scientists actively involved in lifetime animal studies sponsored by the Department are participating in the work of the National Academy of Sciences' Committee on Animal Models for Research on Aging. This committee was established in September 1977 to evaluate small vertebrates as animal models for research on aging.

As in previous years, research directly concerned with the aging process was conducted on a limited scale at several of the Department's contractor facilities. Particular interest has continued at the Argonne National Laboratory and the Oak Ridge National Laboratory. Interest at the Argonne facility focuses principally on the evolutionary comparative paradigm of aging and longevity in which genetic considerations play a prominent role. Mr. George A. Sacher of the Argonne staff served during the year as president of the Gerontological Society. The Oak Ridge program is oriented toward molecular and cellular studies including research on the error theory of aging. This program is conducted jointly with the University of Tennessee Graduate School of Biomedical Sciences and is partly supported by a training grant from the National Institute on Aging. Research on the aging process is also conducted at the Brookhaven National Laboratory, the

Lawrence Berkeley Laboratory, and elsewhere but primarily on a small scale and on a short-term of periodic basis.

Summarized below is research on or related to aging that the Department sponsored in 1978.

LONG-TERM STUDIES OF HUMAN POPULATIONS

These studies provide valuable data on health effects and life-shortening in human populations exposed to hazardous chemical and physical agents associated with the energy technologies. Additional information on life span and aging in human populations is also collected. Since long-term studies of human populations are costly, time-consuming, and complex, they are initiated on a highly selective basis.

The Radiation Effects Research Foundation (RERF), which is sponsored jointly by the governments of the United States and Japan, continued work on a large-scale lifetime followup of survivors of atomic bombings that occurred in Hiroshima and Nagasaki in 1945. Over 100,000 persons are under observation in this study. Detailed clinical and laboratory studies as well as the collection of mortality and autopsy data are performed on both irradiated and control populations in order to identify diseases that have contributed to elevated morbidity and life-shortening among survivors. An important feature of the RERF program is the acquisition of valuable quantitative data on dose-response relationships. Useful data on genetic effects are also being collected. From time to time studies specifically concerned with age-related changes are conducted. Based on extensive data, it was recently reported that the "Effects of ionizing radiation on mortality are specific and focal, and principally carcinogenic. It lends no support to the view that ionizing radiation causes premature aging in man or that the carcinogenic effect is merely a part of general acceleration of aging."

After being accidentally exposed in 1954 to radioactive fallout released during the atmospheric testing of a thermonuclear device, a group of some 200 inhabitants of the Marshall Islands has been followed clinically, along with unexposed controls, by medical specialists at the Brookhaven National Laboratory. The clinical followup has continued on a semiannual basis. Thyroid pathology, which has generaly responded well to therapy or surgery, has been prevalent in individuals heavily exposed to radioiodine.

Nearly 2,000 persons exposed to radium occupationally or for medical reasons have been studied at the Center for Human Radiobiology, Argonne National Laboratory. Many individuals in the study receive medical and radiologic (dosimetric) examinations at the center. Autopsy data are obtained when possible. Current work emphasizes the study of persons with relatively low body burdens of radium. Valuable data on tumor induction by bone-seeking, alpha-emitting radionuclides such as radium-226 are being generated in this study. Of particular importance are quantitative dose-response data for tumorigenesis. The center recently initiated an epidemiologic study of a large worker population occupationally exposed to theorium (an alpha-emitting radioelement) by inhalation during the period from about 1935 to 1974. This study utilizes vital statistics, employment histories, and records from the Social Security Administration to evaluate health effects of internally deposited thorium. Medical and radiologic examinations are being conducted on 100 randomly selected workers. Data on both morbidity and mortality are being collected. The center is also conducting a followup study in a small group of exposed humans to evaluate late-appearing health effects of plutonium.

At the Los Alamos Scientific Laboratory, an epidemiologic study of plutonium workers, past and present, at six Department of Energy facilities is in progress. This study involves a lifetime surveillance of worker health and causes of death. An estimated 15,000–20,000 workers will be followed in the study of mortality data and at least one-third of these will also be studied further by collecting detailed morbidity and personal-history data periodically via questionnaires. Data on internal dosimetry are routinely collected in order to study dose-response relationships. Autopsy data are obtained through the U.S. Transuranium Registry (see below).

A population of some 170,000 past and present contractor employees at Department of Energy production and laboratory facilities is being analyzed in an epidemiologic study designed to assess health effects produced by long-term exposure to low levels of ionizing radiation. Worker populations at the Hanford

(Washington) and Oak Ridge (Tennessee) plants plus a smaller group of contractor employees at the Mound Laboratory (Miamisburg, Ohio) are the subjects of the study, which is directed by the staff at the Oak Ridge Associated Universities (ORAU) with assistance in data collection and processing from teams at each of the facilities that house the workers' records. The study involves the statistical analysis of work records, medical records, and vital statistics (including mortality data and causes of death). Radiation dosimetry as well as exposures to other toxic agents in the work environment are carefully evaluated.

The U.S. Transuranium Registry, which is operated by the Hanford Environmental Health Foundation, collects occupational data (work, medical, and radiation exposure histories) as well as information on mortality and causes of death in worker populations occupationally exposed to plutonium or other transuranium radioelements. Detailed autopsy data are obtained on workers registered with the Foundation at the time of death. Every effort is made to obtain good dosimetric data on all registrants. At the present time, some 14,500 workers from 10 facilities are registered with the foundation, and 73 autopsies have been performed. The autopsy data are made available for use in ongoing epidemiologic studies such as the ORAU study of radiation workers and the Los Alamos study of plutonium workers.

Two lifetime studies of human populations occupationally exposed to hazardous agents associated with nonnuclear energy technologies have been initiated and are getting underway. One involves a large population (thousands) of workers in California who are routinely exposed to low levels of volatile hydrocarbons during their occupational activities in the petroleum transporting and refining industries. The incidence of cancer and respiratory diseases in these workers and a control population is being determined using health records, data from the California Cancer Registry, and findings from annual physical examinations. The other new project is an epidemiologic study of workers at the Paraho oil-shale retorting plant located at Anvil Points, Colo. In this case, a small population of about 100 workers exposed to oil-shale dust and fugitive emissions from the retorting process is being studied to identify possible work-related health effects. The study involves an occupational survey (medical records), industrial hygiene survey (in-plant monitoring of fugitive emissions), and periodic physical examination of workers.

LIFETIME STUDIES IN SHORT-LIVED MAMMALS

Although data from exposed human populations are indispensable in the assessment of health impacts associated with any hazardous agent, limitations inherent in human studies make it mandatory to acquire a substantial body of quantitative data from carefully controlled lifetime studies of animal populations. Reliable data from animal surrogates significantly enhance predictive capabilities. For purposes of comparison and a better understanding of variables affecting response patterns, data from both short-lived and long-lived mammals are needed.

Small rodents with life spans of 2–3 years(rats, mice, hamsters) provide lifetime data in a minimum of time and at low cost. Because of these advantages, rodent populations have been extensively used in large scale studies of late somatic and genetic effects induced by low doses of ionizing radiation. For example, at the Argonne National Laboratory and the Oak Ridge National Laboratory combined, more than 50,000 mice have been exposed to various doses of externally applied ionizing radiation delivered in different daily increments in order to characterize radiation-induced diseases and abnormalities that reduce the life span under various exposure regimes. These studies, in which both gamma and neutron radiations have been employed, continue to yield valuable information on the importance of dose rate and radiation quality as variables affecting mammalian responses to radiation stress. In addition, the careful study of control (unexposed) populations is providing valuable data on life span, morbidity patterns, and causes of death in unstressed animals. Additional lifetime studies of tumorigenesis and other late-appearing somatic effects of ionizing radiation in rodent populations have been carried out at the Brookhaven National Laboratory, the Lawrence Berkeley Laboratory, the Los Alamos Scientific Laboratory, the Battelle-Pacific Laboratory, the Los Alamos Scientific Laboratory, the Battelle-Pacific Northwest Laboratories, the University of Utah, and the Lovelace Foundation's Inhalation Toxicology Research Institute. These studies have included work with various types of ionizing radiation delivered to the animal body from external radiation sources and from internally deposited radionuclides. Approximately 30,000 rodents are currently under observation in lifetime studies at the abovementioned laboratories. Included in the ongoing effort are studies involving external sources (neutrons, gamma radiation and heavy ionizing particles), actinide isotopes that are present in nuclear fuels (plutonium-239, uranium-232, uranium-233, and others), radium isotopes, and products of nuclear fission (including tritium and krypton-85).

Rodent populations are also utilized in lifetime studies of health effects associated with exposures to energy-related chemical agents. In view of the large number of potentially hazardous materials requiring toxicological evaluation, such studies are conducted as part of a systematic multitiered screening and testing program. The number of ongoing lifetime studies has been increasing as short-term toxicological studies have continued to identify additional requirements for long-term testing. Most of the long-term studies have not been in progress long enough to yield definitive data.

The bulk of the ongoing lifetime studies of chemical agents addresses potential health impacts of present-day and advanced fossil-fuel technologies. Two studies with a generic focus are defining variables that influence tumor induction by polynuclear aromatic hydrocarbons that are present in emissions and effluents from many fossil-fuel operations. One is a study at the Brookhaven National Laboratory in which the induction of mammary tumors in the rat is under investigation. In the other generic study, a better understanding of processes involved in the multistage induction of rodent skin tumors is being gained. Another lifetime study is being performed by investigators at the Pacific Northwest Laboratories to evaluate chronic diseases of the respiratory tract that may be caused by the inhalation of coal dust, diesel-engine exhaust, or combinations of the two. The latter study is defining carcinogenic and other health risks that may exist in coal mines located deep underground.

Four ongoing studies are assessing health risks of coal-combustion technologies. Research at the University of California, Davis, is defining health effects of power-plant fly ash, alone and in combination with sulfur-containing emissions (sulfur dioxide or sulfates), using rats subjected to long-term exposures by inhalation. The major objective of this study is to determine functional and morphologic consequences of damage to the respiratory tract. At the Inhalation Toxicology Research Institute, Lovelace Foundation, lifetime studies of rodents chronically exposed to emissions from conventional and fluidized-bed combustion faciliites are in progress. Initial studies are concerned with particulate emissions (fly ash). Biological end points being assessed are life-span shortening, functional disorders, and structural changes, including carcinogenesis. Two projects at the Pacific Northwest Laboratories are devoted to the study of the chronic toxicity of metals and metal oxides present in emissions and effluents from coal-combustion facilities. In these studies, rodents are exposed by ingestion and by inhalation. Special emphasis is placed on evaluating iron-deficient and newborn animals as subpopulations particularly sensitive to toxic metals. Ongoing work is evaluating aspects of cadmium toxicity.

A number of lifetime health-effects studies are conducted in connection with technologies concerned with the conversion of coal to secondary fuels and the extraction of oil from oil shale. Two studies at the Argonne National Laboratory are underway to assess the cancer incidence and life-span reduction caused by exposure to polynuclear aromatic hydrocarbons produced or released as a consequence of coal-gasification and coal-liquefaction. The Argonne program emphasizes research on the role of cancer-promoting agents in the enhancement of tumor yield and reduction of the latent period for malignant tumor production in skin, lung, and liver. At the Oak Ridge National Laboratory, lifetime animal studies are evaluating on a comparative basis skin, lung, and nonspecific cancer caused by various classes of compounds found in coal-liquefaction products. A related project has begun to assess the chronic toxicity of various classes of chemical agents found in effluents and waste products from coal-liquefaction operations. Lifetime studies in rats and hamsters now in progress at the University of Connecticut, Farmington, are defining chronic toxicity and carcinogenic risks associated with the ingestion and inhalation of nickel-containing materials present in waste streams of coal-gasification facilities. Health risks associated with the solvent refining of coal to a solid fuel (SRC I product) and to a liquid fuel (SRC II product) are being defined at the Pacific Northwest Laboratories, where long-term studies of rodents chronically exposed by inhalation or dermal application to components of process streams and fugitive emissions are in progress. Also in progress at the Pacific Northwest Laboratories is a project designed to assess chronic pulmonary toxicity of raw and spent oil shale and to define the pulmonary carcinogenicity of crude shale-oil fractions.

Additional lifetime studies involving short-lived animals have been initiated to increase knowledge regarding the inhalation toxicity of asbestos-containing insulating materials and of aerosols containing strong mineral acids of the type present in effluents and emissions from some energy-producing operations. These studies are conducted at the Pacific Northwest Laboratories and the New England Deaconess Hospital, respectively. In both cases, emphasis is directed toward the study of tumor induction. In the asbestos study, tumorigenesis after oral intake or intra peritoneal administration of the toxic agent is also under evaluation.

LIFETIME STUDIES WITH LONG-LIVED MAMMALS

From the point of view of life span and certain of the organ systems of particular interest, long-lived mammalian species represent better human surrogates than do their short-lived counterparts. This being the case, it is desirable to obtain quantitative data on responses of long-lived species to hazardous agents of concern. The beagle dog, with a life expectancy about one-fifth that of man, has served for more than 20 years as the long-lived mammal used in lifetime radiation-effects studies sponsored by the Department of Energy. Data from studies with beagles significantly facilitate attempts to interrelate data on animal responses with human response patterns. At the Argonne National Laboratory, the University of Utah, the University of California (Davis), the Inhalation Toxicology Research Institute (Lovelace Foundation), and the Pacific Northwest Laboratories, more than 5,000 beagles have lived out their lives under careful experimental observations. In lifetime studies at these research centers, periodic clinical examinations and laboratory analyses are performed on all populations, exposed and control, and complete data on gross pathology and histopathology are collected at autopsy. Accumulated data contain a wealth of information on life span, age-related changes, morbidity, mortality, and causes of death in normal animals, as well as alterations in these characteristics that are induced by superimposed radiation stress. Approximately 3,000 beagles are currently under scrutiny in lifetime studies of late-appearing radiation effects. Included are studies of external radiation (gamma radiation) and internally deposited radionuclies of various types administered by inhalation, ingestion, or injection. All ongoing studies involve careful dosimetric measurements and the acquisition of dose-response data.

Because of their cost and the time required for completion, lifetime studies of beagle populations are initiated on a highly selective basis. No energy-related agent other than ionizing radiation has yet been evaluated in the beagle. It is anticipated that limited studies of other agents will be undertaken in the future as needs for such efforts are identified by shorter-term testing in other systems.

RESEARCH MORE DIRECTLY CONCERNED WITH AGING

Several foci of interest within the Department of Energy laboratory system sustain a low level of research directly related to the aging process.

Ongoing studies at the Argonne National Laboratory are primarily concerned with developing an evolutionary-comparative paradigm of aging and longevity. This effort seeks to explain differences in life span of animal species on the basis of the natural selection of genetically determined traits. The Argonne investigators favor the view that longevity in mammalian species has evolved from a selection of traits conferring on individuals a life span and vigor compatible with effective growth, development, and reproduction. Experimentally, comparative longevity research is conducted with small laboratory and wild rodents having life spans ranging from 2 to 6 years. Various molecular, metabolic, and functional activities are under study in these species.

Over the years, extensive work on molecular, cellular, and physiologic aspects of biological aging have been conducted at the Oak Ridge National Laboratory. For example, Oak Ridge investigators completed a substantial number of studies that have helped define age-related changes in the immune system of irradiated and unexposed rodent populations. Although age-related changes in immune function remain of interest from the point of view of tumor induction, the chief focus of ongoing research at Oak Ridge is directed toward molecular and cellular aspects of aging. Work continues on the multispecies comparative study of correlations that may exist between longevity of organisms and cellular capacity for the repair of damage in DNA molecules that encode genetic information. Additional work has been completed on the study of the error theory of aging, according to which the fidelity of amino acid incorporation into large protein molecules declines progressively with animal age. The magnitude of error has been determined by measuring the extent to which an amino acid analog is inserted by mistake into the mouse hemoglobin molecule. Errors were found to increase with age and with certain treatments to which mice were subjected. Preliminary findings from another study have shown that erythrocytes (red blood cells) of genetically anemic mice suffering from α-thalassemia have a reduced life span. The possible relationship of this phenomenon to the reduced life expectancy of the α-thalassemic mouse is under further study.

Interest in research on the aging process has also continued at the Brookhaven National Laboratory and the Lawrence Berkeley Laboratory. Brookhaven investigators are pursuing their interest in the Hayflick theory of cellular aging (limited or finite reduplication potential of normal mammalian cells). Evidence consistent with the Hayflick concept was obtained from a previous study in mice, and preparations are being made for testing the theory in a human subpopulation (patients with chronic inflammatory disease). From the study of long-term cultures of primary avian tendon cells, investigators at the Lawrence Berkeley Laboratory have concluded that the ability of a tendon cell to regulate collagen production, which is affected by cell maturation and cell density, has important implications both for the process of development and the occurrence of senescence.

TRENDS AND PROSPECTS

Given the need to assess long-term and late-appearing effects of hazardous agents associated with energy-production technologies, lifetime studies of animal and human populations will continue. It is evident, in fact, that additional lifetime studies of chemical agents will be needed in the future. Accordingly, more data describing age-related changes should be forthcoming, and a modest program of research on the aging process itself is expected to continue.

SUMMARY OF RESEARCH SUPPORT

Table I provides a summary of Department of Energy support of research related to aging for fiscal year 1978.

TABLE I.—RESEARCH RELATED TO AGING SPONSORED IN FISCAL YEAR 1978 BY THE DEPARTMENT OF ENERGY

Research category	Projects	Funding [1] (thousands)
Research directly related to aging:		
Cellular and molecular systems	5	$257
Organs and tissues	1	46
Organisms	1	200
Research indirectly related to aging:		
Lifetime studies of short-lived animals (nuclear)	15	4, 673
Lifetime studies of short-lived animals (nonnuclear)	17	3, 117
Lifetime studies of long-lived animals	11	6, 209
Lifetime studies of human populations (nuclear)	11	5, 618
Lifetime studies of human populations (nonnuclear)	2	115
Total	63	20, 235

[1] Total operating dollars.

ITEM 5. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

ADMINISTRATION ON AGING

1. INTRODUCTION

Since its creation by the Older Americans Act of 1965, the Administration on Aging has devoted each year's effort to developing, strengthening, and expanding the capacity of the growing aging network of State and area agencies on aging, multipurpose senior centers, nutrition projects, and other service providers to meet the needs of older persons. A wide variety of activities are being encouraged by the Administration on Aging to help assure that needed social, nutrition, and health-related services are being made available to older persons.

These activities in behalf of the Nation's growing elderly population take on increasing urgency with each passing year. In 1940, 7 percent of the total population was 65 or over. Today the proportion is 11 percent (more than 24 million). After 2010 as the children of the postwar "baby boom" become older, we expect to experience a "senior boom." It is estimated that by the year 2030, 55 million persons will be 65 years or older, which could be almost 1 in 5 of the total U.S. population. The composition of the older population is also changing. In 1950 30 percent of the elderly were 75 or older. There are indications that by the year 2000, 45 percent or almost one-half of the over-65 population will be 75 years old. Advanced age often implies the need for compensatory services to deal with loss in functional capacity.

Aging is a complex process involving biological, psychological, and social changes which reduce people's ability to cope with demands of daily life. The nature and rate of such change varies from person to person and may be thought of as a continuum of loss. This creates the need for a broad spectrum of services which can meet the needs of the well and the vulnerable aged. The well elderly are those who function at or near self-sufficiency. This group includes those who need and want no supportive services, those who may only need part-time employment or volunteer opportunities, those who need a specific service such as transportation where none is available, and those who need the services of a senior center or nutrition site to avoid social isolation. The "vulnerable" elderly are those who have proceeded further along the loss continuum and must depend on others for support to remain in the community. The "vulnerable" include those older persons for whom the problems and functional losses of aging are compounded by insufficient income, isolation, lack of family for support, and advanced age. The vulnerable elderly today may comprise between 3.5 to 4.5 million persons. It is a population group which is expected to continue to expand at an average rate of 80,000 persons per year for the next 50 years.

Fiscal year 1978 was one of both continuity and change. The Administration on Aging continued to build on the framework and principles established and developed in preceding years while strengthening and expanding its capacity to serve growing numbers of older persons in new ways. On February 16, 1978, Robert C. Benedict, formerly commissioner of the Pennsylvania Office for the Aging, was sworn in as the fourth U.S. Commissioner on Aging. Dr. Arthur Flemming, after 5 years as Commissioner, continues as Chairman of the U.S. Civil Rights Commission.

During fiscal year 1978, Congress, with the advice and assistance of the Administration on Aging and other components of the executive branch, developed the "Comprehensive Older Americans Act Amendments of 1978" to extend the authorizations of the Older Americans Act and to improve it in various ways. The amendments were enacted shortly after the end of the fiscal year as Public Law 95-478 (Oct. 18, 1978).

The 1978 amendments gave increased emphasis to both the advocacy and service system development activities on which AOA's policies and programs have focused. The legislation now provides an explicit statutory base for AOA to serve as the "effective and visible advocate for the elderly." In addition State and area agencies on aging are to serve as advocates for older Americans at their respective governmental levels.

The 1978 amendments also strengthened the provisions of the OAA relating to development of the "comprehensive and coordinated service system[s] to serve older individuals" mandated in title III. A "continuum of care for the vulnerable elderly" must be established as part of the "comprehensive and coordinated service systems." In addition, the amendments strengthen the community-level service delivery focus of the Older Americans Act by requiring each area agency on aging to establish, "where feasible, a focal point for comprehensive service delivery in each community." Top priority is being given during fiscal year 1979 to implementing these amendments.

2. Title III Services to Older Americans

Under title III, a national network on aging has been developed. At the end of fiscal year 1978, 568 of 612 State-designated planning and service areas now have operational area agencies on aging. This represents an increase of 12 new area agencies since the end of fiscal year 1977, and means that 92 percent of the Nation's elderly live in areas with an active area agency on aging.

State agencies: In fiscal year 1978, under title III, the 56 State agencies on aging[1] were awarded $19 million in formula grants for administrative activities. State agencies on aging, before the 1978 amendments, were required to submit an annual plan, signed by the Governor, for approval and funding by the Administration on Aging. Title III grants pay up to 75 percent of the cost of staffing and operating the State Agency to:

—Prepare and administer the State plan;
—Evaluate activities carried out under the plan;
—Collect data and carry out analyses related to the need for social services within the State;
—Disseminate the information so obtained;
—Provide short-term training for personnel in programs authorized by the act;
—Carry out demonstration projects of statewide significance.

Area agencies on aging: States were awarded $152,726,446 in title III formula grants to pay part of the operating costs of area agencies on aging and for the funding of social services. Allotments of these funds are shown in table II. Area agencies on aging are public or private nonprofit agencies designated by the State agencies on aging to develop an area plan and to carry out directly or through contractual or other arrangements, a program in accordance with the plan.

During 1978, each area agency on aging was required to submit an annual plan to its State agency for approval and funding. This plan covered area agency administration and set forth the community service system development objectives for the year. Title III area planning and social service funds were available at the following different matching ratios under the Older Americans Act prior to the 1978 amendments:

—Maximum of 15 percent of title III State allotment available for administration of area agencies, with a Federal matching share of up to 75 percent.
—Maximum of 20 percent of the State allotment available for paying the cost of services which were not provided as part of an area plan approved by the State agency, with a Federal matching share of up to 75 percent.
—The remainder available for paying the cost of services provided as part of a comprehensive and coordinated system in planning and service areas for which there was an approved annual plan, with a Federal matching share of up to 90 percent.

Pooling resources to increase services: State and area agency pooling activities involve the generation of funds and resources from other public and private agencies to expand services or initiate new activities for the benefit of older persons. By the end of fiscal year 1978 State and area agencies increased the amount of total resources pooled by $152,325,722 over fiscal year 1977, as shown in table I, below.

TABLE I.—STATE AND AREA AGENCY POOLING ACTIVITY, FISCAL YEAR 1978

[Dollars, in thousands]

Source	Amount	Percent
Local government	$131,070.099	19
State appropriated	46,874.507	07
Other Federal	511,914.6	74

	1975	1976	1977	1978
Total resources pooled[1]	$122,541	$245,930	[2] $440,403.806	[3] $689,859.206
Percent cash	80	65	51	33
Amount of cash	98,000	140,000	224,000	227,000

[1] Excludes funds received under all titles of the Older Americans Act except title relating to older American community service employment program.
[2] Based upon information received from all U.S. jurisdictions except 3.
[3] Based upon information received from all U.S. jurisdictions except 8.

---

[1] Includes the 50 States plus American Samoa, Guam, Puerto Rico, the Trust Territory of the Pacific Islands, the Virgin Islands, and the District of Columbia.

TABLE II.—ALLOTMENTS OF FISCAL YEAR 1978 FORMULA GRANTS UNDER TITLE III[1] OF THE OLDER AMERICANS ACT OF 1965, AS AMENDED

States	Population 60 and over July 1, 1976		Title III	
	Unrounded population	Percent distribution	State administration	Area planning and social services
Total 56 States	32, 558, 754	100. 0000	$19, 000, 000	[2] $151, 470, 000
Alabama	546, 307	1. 6779	268, 982	2, 438, 377
Alaska	16, 974	. 0521	200, 000	757, 350
Arizona	332, 199	1. 0203	200, 000	1, 482, 731
Arkansas	377, 796	1. 1604	200, 000	1, 686, 248
California	3, 016, 384	9. 2644	1, 485, 160	13, 463, 275
Colorado	310, 712	. 9543	200, 000	1, 386, 826
Connecticut	475, 607	1. 4608	234, 172	2, 122, 815
Delaware	73, 513	. 2258	200, 000	757, 350
District of Columbia	101, 507	. 3118	200, 000	757, 350
Florida	1, 820, 777	5. 5923	896, 486	8, 126, 822
Georgia	630, 865	1. 9376	310, 616	2, 815, 791
Hawaii	91, 781	. 2819	200, 000	757, 350
Idaho	118, 076	. 3627	200, 000	757, 350
Illinois	1, 666, 301	5. 1178	820, 428	7, 437, 337
Indiana	756, 959	2. 3249	372, 700	3, 378, 597
Iowa	496, 744	1. 5257	244, 579	2, 217, 158
Kansas	391, 990	1. 2039	200, 000	1, 749, 601
Kentucky	519, 9[illegible]9	1. 5970	256, 009	2, 320, 775
Louisiana	500, 581	1. 5375	246, 468	2, 234, 284
Maine	175, 899	. 5403	200, 000	785, 104
Maryland	513, 959	1. 5786	253, 055	2, 293, 995
Massachusetts	948, 643	2. 9136	467, 078	4, 234, 156
Michigan	1, 191, 586	3. 6598	586, 695	5, 318, 503
Minnesota	607, 980	1. 8673	299, 348	2, 713, 647
Mississippi	353, 370	1. 0853	200, 000	1, 577, 225
Missouri	822, 220	2. 5253	404, 832	3, 669, 881
Montana	111, 222	. 3416	200, 000	757, 350
Nebraska	262, 863	. 8073	200, 000	1, 173, 258
Nevada	72, 675	. 2232	200, 000	757, 350
New Hampshire	125, 431	. 3852	200, 000	757, 350
New Jersey	1, 134, 589	3. 4847	558, 631	5, 064, 103
New Mexico	136, 853	. 4203	200, 000	757, 350
New York	2, 926, 553	8. 9885	1, 440, 931	13, 062, 322
North Carolina	736, 824	2. 2631	362, 786	3, 288, 727
North Dakota	104, 960	. 3224	200, 000	757, 350
Ohio	1, 536, 038	4. 7177	756, 291	6, 855, 923
Oklahoma	464, 520	1. 4267	228, 713	2, 073, 330
Oregon	375, 782	1. 1542	200, 000	1, 677, 258
Pennsylvania	2, 007, 084	6. 1645	988, 217	8, 958, 381
Rhode Island	161, 463	. 4959	200, 000	757, 350
South Carolina	347, 475	1. 0672	200, 000	1, 550, 913
South Dakota	118, 029	. 3625	200, 000	757, 350
Tennessee	634, 594	1. 9491	312, 452	2, 832, 435
Texas	1, 677, 411	5. 1520	825, 898	7, 486, 925
Utah	134, 766	. 4139	200, 000	757, 350
Vermont	72, 073	. 2214	200, 000	757, 350
Virginia	640, 313	1. 9666	315, 267	2, 857, 961
Washington	523, 022	1. 6063	257, 508	2, 334, 357
West Virginia	305, 835	. 9393	200, 000	1, 365, 058
Wisconsin	724, 460	2. 2251	356, 698	3, 233, 541
Wyoming	51, 350	. 1577	200, 000	757, 350
American Samoa	1, 100	. 0034	62, 500	378, 675
Guam	3, 200	. 0098	62, 500	378, 675
Puerto Rico	297, 400	. 9134	200, 000	1, 327, 410
Trust Territory	6, 500	. 0200	62, 500	378, 675
Virgin Islands	5, 700	. 0175	62, 500	378, 675

---

[1] Does not include sec. 308 model project discretionary grants.

[2] Initial allotment amount. Total allotted after reallotments was $152,726,446.

Title III services: Title III of the Older Americans Act established State and community programs for older persons and stressed the provision of national priority services which were transportation, in-home services, legal and other counseling, and home repair. Priority is given to serving the low-income and minorities. Table III shows the number of units of each type of service provided by title III under area plans during 1976, 1977, and 1978.

TABLE III.—UNITS OF SERVICE PROVIDED BY TITLE III UNDER AREA PLANS

Type of service	Units of service		
	1976	1977	1978[1]
Transportation	1,790,000	2,451,000	2,546,000
In-home services	200,000	486,529	759,000
Information and referral	1,692,000	3,171,946	2,800,000
Legal and other counseling	92,000	198,369	266,000
Home repair	23,000	77,892	95,000
Escort	158,000	289,754	377,000
Outreach	806,000	1,430,966	1,600,000
All other services	1,322,000	3,110,001	4,200,000
Total	6,083,000	11,216,457	12,643,000

[1] 1978 column includes data relating to all jurisdictions except 3, which did not report.

Note: The total of 12,643,000 units of service represents an increase of 1,426,543 since fiscal year 1977. State and area agencies have been increasingly successful in establishing connecting links with other agencies and organizations to encourage the allocation of additional resources to help meet the service needs of older persons.

Involving older persons: Area agencies on aging are required to involve older persons in their programs and activities. Area agencies have fulfilled this responsibility by significant employment and meaningful use of older volunteers, as follows:

	Fiscal year 1978
Paid staff:	
60 years or older	1,810
Volunteer staff:	
60 years or older	19,201

25 percent of total paid staff members were aged 60 and over in fiscal year 1978. 84 percent of total volunteer staff members were aged 60 and over in that year.

In addition, many older persons serve voluntarily on advisory councils of area agencies on aging, in compliance with the requirement of the Older Americans Act that such councils include representatives of the target population and the requirement in the regulations that older persons compose at least 50 percent of the membership of these councils.

3. NUTRITION PROGRAM

The nutrition program began operations in fiscal year 1973. In fiscal year 1978 funds amounting to $250 million were appropriated under title VII of the Older Americans Act and were awarded by formula grants to the State agencies on aging to pay up to 90 percent of the cost of providing meal services to older persons. State agencies on aging awarded grants to public or private nonprofit agencies to establish community-based nutrition projects. These projects managed nutrition sites which furnished low-cost, hot-nutritious meals and support services to persons 60 years of age and over and their spouses. Although the emphasis has been on serving meals in congregate settings to reduce social isolation, many projects also deliver meals to the homebound.

During 1978, each project was required to provide at least one hot meal per day 5 or more days a week throughout the year. Nutrition projects provided support services needed to facilitate participation in the program such as outreach, transportation, and escort services. In addition, projects were encouraged to offer health, education, counseling, shopping assistance, information and referral, and recreational services.

During 1978, the purpose of the nutrition program was to help supplement the nutritional and social needs of older persons who did not eat adequately for one or more of the following reasons:

—They could not afford to do so.

—They lacked the skills to select and prepare nourishing and well-balanced meals.

—They had feelings of rejection and loneliness which obliterated the incentive to prepare and eat a meal alone.

—Their mobility was limited, which could have impaired their capacity to shop and cook for themselves.

Table IV summarizes pertinent facts on the program. Allocation of title VIII fiscal year 1978 funds is shown in table V.

TABLE IV.—TITLE VII NUTRITION PROGRAM SUMMARY

	Fiscal year 1975	Fiscal year 1976	Fiscal year 1977	Fiscal year 1978	Fiscal year 1977-78 change
Number of projects	628	845	1, 047	1, 101	+54
Number of sites	4, 491	6, 672	9, 166	10, 681	+1, 515
Total meals served	52, 276, 000	64, 273, 000	101, 091, 000	134, 418, 121	+33, 327, 121
Average number of meals served daily	209, 104	247, 000	388, 000	509, 000	+121, 000
Estimated number of different persons served	1, 470, 000	1, 723, 000	2, 854, 755	2, 744, 781	−109, 974
Average cost of meals (food and preparation only)	$1. 64	$1. 63	$1. 73	$1. 80	+$0. 07
Average total program cost of meal	$2. 26	$2. 25	$2. 46	$2. 55	+$0. 09
Percent home delivered meals	13	14	15	17	+2
Percent expended on supporting social services	13	11	14	15	+1
Percent minority	24	21	22	23	+1
Percent low income	62	62	67	64	−3
USDA commodities contributions	$3, 263, 000	$10, 500, 000	$14, 615, 853	$20, 464, 844	+$5, 848, 991

TABLE V.—FISCAL YEAR 1978 STATE ALLOTMENT AMOUNTS UNDER TITLE VII OF THE OLDER AMERICANS ACT OF 1965, AS AMENDED

States	Population 60 plus and over, July 1, 1976		
	Unrounded population	Percent distribution	Title VII, nutrition [1] program
Total 56 States	32, 558, 754	100. 0000	$247, 500, 000
Alabama	546, 307	1. 6779	3, 984, 275
Alaska	16, 974	. 0521	1, 237, 500
Arizona	332, 199	1. 0203	2, 422, 763
Arkansas	377, 796	1. 1604	2, 755, 307
California	3, 016, 384	9. 2644	21, 998, 812
Colorado	310, 712	. 9543	2, 266, 056
Connecticut	475, 607	1. 4608	3, 468, 653
Delaware	73, 513	. 2258	1, 237, 500
District of Columbia	101, 507	. 3118	1, 237, 500
Florida	1, 820, 777	5. 5932	13, 279, 121
Georgia	630, 865	1. 9376	4, 600, 966
Hawaii	91, 781	. 2819	1, 237, 500
Idaho	118, 076	. 3627	1, 237, 500
Illinois	1, 666, 301	5. 1178	12, 152, 511
Indiana	756, 959	2. 3249	5, 520, 583
Iowa	496, 744	1. 5257	3, 622, 807
Kansas	391, 990	1. 2039	2, 858, 825
Kentucky	519, 959	1. 5970	3, 792, 117
Louisiana	500, 581	1. 5375	3, 650, 791
Maine	175, 899	. 5403	1, 282, 850
Maryland	513, 959	1. 5786	3, 748, 358
Massachusetts	948, 643	2. 9136	6, 918, 555
Michigan	1, 191, 586	3. 6598	8, 690, 364
Minnesota	607, 980	1. 8673	4, 434, 063
Mississippi	353, 370	1. 0853	2, 577, 165
Missouri	822, 220	2. 5253	5, 996, 538
Montana	111, 222	. 3416	1, 237, 500
Nebraska	262, 863	. 8073	1, 917, 088
Nevada	72, 675	. 2232	1, 237, 500
New Hampshire	125, 431	. 3825	1, 237, 500
New Jersey	1, 134, 589	3. 4847	8, 274, 679
New Mexico	136, 853	. 4203	1, 237, 500
New York	2, 926, 553	8. 9885	21, 343, 664
North Carolina	736, 824	2. 2631	5, 373, 736
North Dakota	104, 960	. 3224	1, 237, 500
Ohio	1, 536, 038	4. 7177	11, 202, 489
Oklahoma	464, 520	1. 4267	3, 387, 794
Oregon	375, 782	1. 1542	2, 740, 618
Pennsylvania	2, 007, 084	6. 1645	14, 637, 878
Rhode Island	161, 463	. 4959	1, 237, 500
South Carolina	347, 475	1. 0672	2, 534, 172
South Dakota	118, 029	. 3625	1, 237, 500
Tennessee	634, 594	1. 9491	4, 628, 162
Texas	1, 677, 411	5. 1520	12, 233, 538
Utah	134, 766	. 4139	1, 237, 500
Vermont	72, 073	. 2214	1, 237, 500
Virginia	640, 313	1. 9666	4, 669, 871
Washington	523, 002	1. 6063	3, 814, 310
West Virginia	305, 835	. 9393	2, 230, 487
Wisconsin	724, 460	2. 2251	5, 283, 564
Wyoming	51, 350	. 1577	1, 237, 500
American Samoa	1, 100	. 0034	618, 750
Guam	3, 200	. 0098	618, 750
Puerto Rico	297, 400	. 9134	2, 168, 970
Trust Territory	6, 500	. 0200	618, 750
Virgin Islands	5, 700	. 0175	618, 750

---

[1] Of the $250,000,000 fiscal year 1978 appropriation for title VII, $247,500,000 was for project support, $2,500,000 for program evaluation.

4. Multipurpose Senior Centers Program

Multipurpose senior centers are community facilities which function as service delivery centers for the provision of a wide variety of social, health, nutritional, educational, and recreational services as needed by older persons.

During 1978, the multipurpose senior center title of the Older Americans Act was title V, which provided Federal funds to pay up to 75 percent of the cost of acquiring, altering, or renovating existing facilities to serve as multipurpose senior centers. These funds could also be used to pay part of the cost of initial equipment of such centers. The Commissioner was authorized to make grants or contracts to units of general purpose government or other public or private nonprofit agencies or organizations. In order to assure that title V-supported multipurpose senior center facilities were integrated with Older Americans Act title III and title VII social and nutritional services, priority was given to funding applications from State agencies on aging.

The program was funded for the first time during the 1976 transition quarter. A total of 549 grants were awarded from the $5 million appropriated for that period to initiate the program. In fiscal year 1977, with an appropriation of $20 million, a total of 1,221 grants were awarded. $40 million was appropriated in fiscal year 1978 to support the title V program. Near the end of fiscal year 1978, single statewide grants were awarded to State units on aging. As this is written, the data is incomplete. Some States may still be in the process of awarding subgrants. Seventeen States were unable to provide data. As of October 1978 a total of 977 awards had been made with fiscal year 1978 appropriations. This included 788 for alteration and renovation and 69 for acquisition of facilities.

The distribution of fiscal year 1978 appropriations for this purpose is shown in table VI.

TABLE VI.—DISTRIBUTION OF FISCAL YEAR 1978 TITLE V SENIOR CENTER APPROPRIATIONS

State	Title V	State	Title V
Total 56 States	$40,000,000	Nevada	$200,000
Alabama	643,923	New Hampshire	200,000
Alaska	200,000	New Jersey	1,337,322
Arizona	391,558	New Mexico	200,000
Arkansas	445,302	New York	3,449,481
California	3,555,366	North Carolina	868,483
Colorado	366,231	North Dakota	200,000
Connecticut	569,590	Ohio	1,810,503
Delaware	200,000	Oklahoma	547,522
District of Columbia	200,000	Oregon	442,928
Florida	2,146,121	Pennsylvania	2,365,718
Georgia	743,590	Rhode Island	200,000
Hawaii	200,000	South Carolina	409,563
Idaho	200,000	South Dakota	200,000
Illinois	1,964,042	Tennessee	747,986
Indiana	892,215	Texas	1,977,137
Iowa	585,504	Utah	200,000
Kansas	462,032	Vermont	200,000
Kentucky	612,867	Virginia	754,727
Louisiana	590,027	Washington	616,454
Maine	207,329	West Virginia	360,483
Maryland	605,795	Wisconsin	853,909
Massachusetts	1,118,150	Wyoming	200,000
Michigan	1,404,503	American Samoa	100,000
Minnesota	716,616	Guam	100,000
Mississippi	416,512	Puerto Rico	350,541
Missouri	969,138	Trust Territory	100,000
Montana	200,000	Virgin Islands	100,000
Nebraska	309,832		

5. Building on the Nursing Home Ombudsman/Legal Services Experience

In fiscal year 1978 a new strategy was developed to maximize the capacity of the aging network to provide broad-based advocacy services to older persons. In June 1978, the Administration on Aging issued guidelines to the States for applying for funds under the older Americans advocacy assistance program which combines the objectives of the legal services and nursing home ombudsman programs into a common framework. The legal services and nursing home ombudsman efforts had been funded separately in the past using model project resources. The Administration on Aging's experiences with the legal services and nursing home ombudsman program led to the conclusion that a comprehensive system of State and community-based advocacy services was need to secure:

—Access to existing rights, benefits, and entitlements which are essential to the enjoyment of a full life for older persons.

—Positive changes in existing rights and benefits as well as development of new mandates to benefit older persons.

The focus is on serving the vulnerable aged—the functionally disabled, the socially isolated, the low income, the very old. The objectives are to serve vulnerable older persons who require assistance in securing their rights, benefits, and entitlements and who require protection from abuse and exploitation. This enlarged effort will be funded with $3 million of fiscal year 1979 demonstration project funds. State allotments range from $50,000 to $130,000 based on elderly population.

AOA has also supported a number of legal services grantees who provide a wide variety of legal and advocacy services for the State and area agencies and older persons, focusing in particular on providing technical assistance to the State legal services and nursing home ombudsman development programs. These grants continued in 1978. However, as part of the new advocacy assistance strategy, AOA decided to convert this effort into a network of resource and support centers funded by contracts rather than grants.

Requests for proposals were issued for six contracts to be awarded in fiscal year 1979. The contracts will be for five biregional resource and support services centers and one nationwide effort to develop specialized resource and training material.

With respect to the nursing home ombudsman and legal services programs, therefore, fiscal year 1978 was a year of transition as AOA prepared to initiate the new advocacy assistance effort. Pending full implementation of the advocacy assistance program, AOA continued its support for the legal services and ombudsman activities, as indicated by the following:

a. *Nursing home ombudsman program:* Since 1976, nursing home ombudsman projects with Federal funds have supported developmental specialists in State agencies on aging. In fiscal year 1978, $1,010,628 in title III, section 308 (model projects) funds were awarded to 47 States, Puerto Rico, and the District of Columbia for the purpose of stimulating State and community activities to benefit older persons needing nursing home care. Nursing home developmental specialists have been involved in the following three areas:

—*Issues advocacy*—which seeks to identify issues of concern and bring about statewide changes in legislation, regulations, and policies to improve long-term care services for the elderly, and to assure compliance with regulations in nursing homes.

—*Personal advocacy*—which establishes and operates a community-based complaint process designed to protect the interests of individual older persons in nursing homes and to document such complaints to serve as a means of identifying advocacy issues.

—*Public education*—which uses the media and other forms to educate the public about the needs and rights of nursing home residents and issues related to long-term care.

State legislation: During fiscal year 1978, there were several important developments. By the end of fiscal year 1978 five States—Connecticut, Maine, New Jersey, South Carolina, and Florida—had passed legislation establishing nursing home ombudsman programs which mandate a range of authorities to the ombudsmen. Several States have introduced ombudsman legislation, while other States are now formulating bills. In Iowa and North Carolina legislation requires development of community care review committees to advocate for improved nursing home care.

Areawide activities: Over 200 ombudsman projects are now operating on the sub-State level while numerous new projects are in the development stage. These projects have been documenting individual complaints and using the data to identify issues affecting institutionalized persons. State level staff then work to secure changes in areas such as:

—Patients' rights.
—Access to nursing homes.
—Penalties for nursing home violations.
—Training and certification of nursing home aides.
—Public disclosure.
—Receivership of homes threatened with closure for failure to meet requirements.
—Reimbursement to providers.
—Management of patients' personal funds.
—Development and/or upgrading of nursing and boarding home regulations.
—Licensure of nursing home administrators.
—Adult abuse.
—Medicaid bed shortage.

A number of States have reported passage of legislation and enactment of regulations in these and other similar areas of concern.

b. *Legal services program:* In fiscal year 1978, title III, section 308 (model projects) funds provided $1,500,000 on a formula grant basis to support continuation of the legal services development projects established in fiscal year 1977 in each State agency on aging. Funds were used to employ a legal services development specialist whose functions included:

—Working with area agencies on aging to help plan and implement legal services programs for older persons.
—Assisting area agencies on aging, legal services corporation offices and/or legal aid programs to expand services and outreach efforts to eligible elderly clients.
—Identifying and securing funding for legal programs to serve older persons.
—Assisting area agencies on aging in involving the private bar in increasing legal representation for older people.
—Stimulating law schools and other educational institutions to provide research, law-related training, and/or direct client services to the elderly.
—Designing and coordinating training programs about the legal concerns of the aged for State and area agency staff, grantee, paralegals, lawyers, and older persons.
—Developing legal support for nursing home ombudsman projects.
—Working with State and area agencies and other interested groups for the enactment of legislation to protect and strengthen the rights of older persons.

In addition, the Administration on Aging continued to support a variety of projects which provided training and technical assistance for State agency staff and local lawyer and nonlawyer advocacy efforts.

6. MANPOWER DEVELOPMENT AND TRAINING PROGRAM

Title IV, part A of the Older Americans Act authorizes the Commissioner to award grants or contracts to public or nonprofit agencies, organizations, or institutions for training projects. The purpose of the IV–A program is to improve the quality of service to older persons by increasing the number of adequately trained personnel in the field of aging.

A. CAREER TRAINING

The Administration on Aging supports training programs in institutions of higher education that will provide students with the necessary gerontology knowledge and skills to enable them to serve the Nation's elderly in their chosen career or profession.

Through the career development program, students are prepared for employment for which baccalaureate, masters, and doctorate level degrees are needed, in such areas as:

(1) State and Federal program planning and administration;
(2) Community development and coordination;
(3) Administration of retirement homes and homes for the aged;
(4) Senior center direction;
(5) Teaching and research; and
(6) Serving older people through adult education, architectural design, counseling, law, library service, recreation, and other relevant fields.

At the close of fiscal year 1978, $7.5 million was awarded on a national competitive basis to 66 educational institutions to support activities relative to career training in aging, with the program emphasis on multidisciplinary efforts of the grantee institutions. Approximately 15,000 students were enrolled in courses and programs in aging. Over 1,000 students received financial assistance as part of the career-training program.

B. INSERVICE TRAINING

The Administration on Aging in fiscal year 1978 continued its grant awards to each State agency on aging for the support of training to meet priority inservice needs identified in each State. A total of $6 million supported inservice training in such areas as gerontology, information and referral, nutrition, program management and analysis, planning, and outreach. More than 130,000 persons now in the field of aging have received training under these programs. Fiscal year 1978 applications for State inservice training were coordinated with the fiscal year 1979 annual State plan and as such were subject to the public hearings process and review by the State Advisory Committee and the Governor.

C. QUALITY IMPROVEMENT GRANTS

In fiscal year 1978, $2.8 million supported 21 quality improvement grants. This category of training grant was first developed for the fiscal year 1976 funding cycle to address the legislative mandate to improve programs for careers in aging. Quality improvement grants are to encourage innovative model projects of potential benefit to the gerontological field and the aging network at large. Many of these projects are directly supportive of other network activities such as:

—KWIC project—Duke University clearinghouse of information on training materials.
—National council on aging developmental project to design model program for training senior center personnel.
—Five law-related projects to provide increased numbers of lay advocates, paralegals, law students, and lawyers with skills to increase service delivery to older persons.

D. MANPOWER DEVELOPMENT

The Administration on Aging, together with the Bureau of Labor Statistics, Department of Labor, has continued to develop information on manpower needs in the field of aging.

Activities conducted included:

—The development and distribution of current vocational guidance information on professional careers in the field of aging for young people enrolled in high schools, vocational and technical schools, colleges and universities.
—Assessment of social work manpower in the field of aging.
—Assessment of agency on aging manpower needs.
—Study of the aging content of ongoing surveys.
—Update on manpower needs in the nursing home industry.
—Assessment of recreational careers related to aging.

E. OTHER MANPOWER AND TRAINING ACTIVITIES

Other significant accomplishments in the area of training and manpower are:

—Continued support of a clearinghouse for available in-service and other training materials.
—Design of model program for training senior center personnel.
—Project to train trainers to develop self-help groups for older persons in areas of health care, safety, and consumer affairs.
—Manpower development projects in specific areas.
    Training for lay advocates, law students, and lawyers in law and aging.
    Curriculum development and training in health-related fields.
    Sensitizing professionals to needs and concerns of minority older persons.

Table VII is a title IV, part A, funding summary, and table VIII is a list of projects supported under that authorization.

TABLE VII.—TITLE IV-A FUNDING SUMMARY (FISCAL YEAR 1975-78)

	Approximate amount (millions)[1]	Grants
Fiscal year 1975—$8,000,000:		
Career	$3.7	50
In-service	3.5	56
Other	.5	6
Fiscal year 1976 and transition quarter—$14,000,000:		
Career	6.0	64
Planning	.3	13
Quality improvement	1.0	14
In-service	6.0	56
Fiscal year 1977—$14,200,000:		
Career	6.0	58
Panning	.5	20
Quality improvement	1.4	16
In-service	6.0	56
Fiscal year 1978—$17,000,000:		
Career	7.5	66
Quality improvement	2.8	21
In-service	6.0	56

---

[1] Depending on the year, balances include other items such as conferences, dissertations, evaluation, etc.

TABLE VIII. FISCAL YEAR 1978 - TITLE IV-A SUPPORTED PROJECTS

State	Grantee	Project Title	Amount	Category
Alabama	University of Alabama in Birmingham	Multidisciplinary Training Grant Program	$196,074	Career
	University of Alabama	A Multidisciplinary Career Training Program in Gerontology	73,733	Career
	National Interfaith Coalition on Aging	Training Project in Gerontology Seminar Faculty and Clergy	125,000	Quality Improvement
	Commission on Aging	State Title IV-A Training	96,333	
Alaska	Office on Aging	State Title IV-A Training	30,000	
American Samoa	Governor of American Samoa	State Title IV-A Training	15,000	
Arizona	University of Arizona	Retirement Housing Administration - Long-Term Care	76,940	Career
Arkansas	University of Arkansas at Pine Bluff	Proposal for Multidisciplinary Training Programs in Gerontology	57,921	Career
	Office of Aging and Adult Services	State Title IV-A Training	67,350	
California	Los Angeles Harbor College	Los Angeles Harbor College Gerontology Services Worker Training Program	37,553	Career
	San Diego State University	Education in Aging with Emphasis on Minority Groups	296,428	Career
	University of California - San Francisco	Training Program in Multidisciplinary Applied Gerontology	130,762	Career
	Office of Aging	State Title IV-A	527,861	

TABLE VIII. FISCAL YEAR 1978 - TITLE IV-A SUPPORTED PROJECTS--Continued

State	Grantee	Project Title	Amount	Category
Colorado	Adams State College	Undergraduate Gerontology and Social Work Education Project	$ 21,100	Career
	University of Denver	Multidisciplinary Career Training in Gerontology	106,937	Career
	Division of Services for the Aging	State Title IV-A Training	54,403	
Connecticut	Department on Aging	State Title IV-A Training	83,267	
	University of Bridgeport	Training Paraprofessionals in Aging	33,146	Career
Delaware	Division on Aging	State Title IV-A Training	30,000	
District of Columbia	American Alliance for Health, Physical Education & Recreation	Model Education and Service Approaches in Health, Fitness and Leisure for the Older Americans	76,838	Quality Improvement
	American Speech and Hearing Association	Multidisciplinary Training Program on Understanding Communication Behavior and Problems of Older Americans	97,618	Quality Improvement
	Antioch School of Law	Law and Aging Curriculum	80,946	Quality Improvement
	George Washington University School of Medicine & Health	Multidisciplinary and Interprofessional Career Training Program in Gerontology	106,547	Career
	George Washington University - National Law Center	Development and Export of Multidisciplinary Training Program for Older Americans	130,742	Career
	Gerontological Society	Foundations for Establishing Educational Programs in Gerontology	75,190	Quality Improvement

TABLE VIII. FISCAL YEAR 1978 - TITLE IV-A SUPPORTED PROJECTS--Continued

State	Grantee	Project Title	Amount	Category
District of Columbia	National Center on Black Aged, Inc.	Quality Improvements for Minorities: Students, Faculty, and Institutions	$107,043	Quality Improvement
	National Council on the Aging, Inc.	Students Centers Planning Project	60,153	Quality Improvement
	National Paralegal Institute	Community Service Training and Demonstrations	166,146	Quality Improvement
	University of D.C. (Mt. Vernon Square)	Institute of Gerontology	127,171	Career
	Center for Human Services	Quality Improvement of Programs for Preparing Personnel in Aging	98,183	Quality Improvement
	Division on Aging	State Title IV-A Training	30,000	
Florida	University of Florida	A Multidisciplinary Program of Career Training in Gerontology	96,238	Career
	University of South Florida	Multidisciplinary Graduate Career Training in Gerontology	67,008	Career
	Division on Aging	State Title IV-A Training	320,927	
Georgia	Albany State College	Career Training - A Student Training Program in Gerontology	21,496	Career
	Georgia State University	Graduate Training Program Sociology of Aging	81,163	Career
	North Georgia College	Career Training in Aging	35,684	Career
	Office of Aging	State Title IV-A Training	111,358	
Guam	Office of Aging	State Title IV-A Training	15,000	

TABLE VIII. FISCAL YEAR 1978 - TITLE IV-A SUPPORTED PROJECTS--Continued

State	Grantee	Project Title	Amount	Category
Hawaii	University of Hawaii at Manoa	Gerontology Training Program	$142,219	Career
	Commission on Aging	State Title IV-A Training	30,000	
Idaho	Idaho Office on Aging	State Title IV-A Training	30,000	
Illinois	University of Chicago	Multidisciplinary Career Training in Aging	181,569	Career
	Southern Illinois Univ. at Carbondale	Multidisciplinary Gerontological Career Training in Welfare	101,521	Career
	Southern Illinois Univ. at Edwardsville	Expansion of Interdisciplinary Graduate Career Training	63,587	Career
	University of Chicago	Symposium on Policy Options for Long-Term Care of the Elderly	130,011	Conference
	Department on Aging	State Title IV-A Training	259,941	Career
Indiana	Commission on Aging and Aged	State Title IV-A Training	134,510	
Iowa	University of Iowa	State University of Iowa Co-operative Training Proposal	115,783	Career
	Commission on Aging	State Title IV-A Training	88,915	
Kansas	Wichita State University	Multidisciplinary and Multi-Level Education and Training Program in Gerontology	76,305	Career
	Division of Social Services	State Title IV-A Training	69,473	
Kentucky	University of Kentucky	Multidisciplinary Career Training in Gerontology	197,468	Career
	Aging Program Unit	State Title IV-A Training	92,824	

TABLE VIII. FISCAL YEAR 1978 - TITLE IV-A SUPPORTED PROJECTS--Continued

State	Grantee	Project Title	Amount	Category
Louisiana	Louisiana Center for Public Interest	Law/Social Work Training Program	$138,217	Quality Improvement
	Northeast Louisiana University	Gerontology Planning Grant	116,243	Career
	Southern University in New Orleans	Career Training - Multidisciplinary Approach in Gerontology	74,190	Career
	Bureau of Aging	State Title IV-A Training	88,627	
Maine	University of Maine at Portland-Gorham	Undergraduate Preparation of Human Service Generalist with Special Emphasis in Gerontology	36,490	Career
	Office of Maine's Elderly	State Title IV-A Training	31,142	
Maryland	Antioch College/Columbia	Career Training in Adult Development and Aging - Two Interdisciplinary Programs	74,548	Career
	Center for Public Management	Practitioner-Led Workshop for Area Agencies on Aging	90,000	Quality Improvement
	University of Maryland	Career Training - Grant to Expand Gerontology Program, Develop Program in Dentistry and Pharmacy and Expand Campus and Intra-Campus Aging Related Programs	114,510	Career
	Office on Aging	State Title IV-A Training	90,119	
Massachusetts	Boston University	Consortium Gerontology Training Programs	197,069	Career
	Department of Elder Affairs	State Title IV-A Training	168,796	
	Harvard University	Health Curricula Improvement in Aging	128,664	Quality Improvement

TABLE VIII. FISCAL YEAR 1978 - TITLE IV-A SUPPORTED PROJECTS—Continued

State	Grantee	Project Title	Amount	Category
Massachusetts	University of Massachusetts	Multidisciplinary Curricula in Aging	$104,957	Career
Michigan	Madonna College	Career Training in Aging: A Multidisciplinary Approach	49,875	Career
	The University of Michigan	Gerontology Career Training Grant	184,607	Career
	Wayne State University	Career Training Program in Aging	169,757	Career
	University of Michigan	Quality Improvement in the Health Sciences	84,999	Quality Improvement
	Western Michigan University	Career Training Support Program in Gerontology	51,139	Career
	Office of Services to the Aging	State Title IV-A Training	211,146	
Minnesota	Governor's Citizens Council on Aging	State Title IV-A Training	108,023	
Mississippi	Mississippi Valley State Universiey	Undergraduate Program in Aging with Emphasis on Minority Aging	87,541	Career
	Council on Aging	State Title IV-A Training	63,033	
Missouri	St. Louis University	Career Training Program in Aging	86,873	Career
	CEMREL, Inc.	Model for Training Counseling Students and Peer Seminars	107,537	Quality Improvement
	Curators of the University of Missouri	Career Training in Gerontology	89,060	Career
	University of Missouri at St. Louis	Gerontology Training Program	113,115	Career
	Office of Aging	State Title IV-A Training	147,193	

TABLE VIII. FISCAL YEAR 1978 - TITLE IV-A SUPPORTED PROJECTS—Continued

State	Grantee	Project Title	Amount	Category
Montana	Aging Services Bureau	State Title IV-A Training	$ 30,000	
Nebraska	The University of Nebraska at Omaha	Gerontology Career Training Program	116,810	Career
	University of Nebraska Medical Center	Title IV-A Career Training Program	100,432	Career
	Commission on Aging	State Title IV-A Training	47,127	
Nevada	Division of Aging	State Title IV-A Training	30,000	
New Hampshire	Council on Aging	State Title IV-A Training	30,000	
New Jersey	Rutgers, The State University	Intra-University Program in Gerontology	132,663	Career
	Seton Hall University	Multidisciplinary Training of Gerontology Personnel	92,500	Career
	College of St. Elizabeth	Gerontology Career Training Program	37,439	Career
	Division on Aging	State Title IV-A Training	200,093	
New Mexico	Commission on Aging	State Title IV-A Training	30,000	
New York	Council on Social Work Education	Develop Knowledge About Needs of Aging Members of Ethnic Minority Groups of Color	82,135	Quality Improvement
	Fordham University	Title IV-A Career Training	99,751	Career
	Graduate School and University Center-CUNY	Self-Help Mutual Aid	50,000	Quality Improvement
	Hunter College	Career Training in Aging	168,832	Career
	Jewish Institute for Geriatric Care	A Training Program for Medical Students in Clinical Care for the Elderly	180,249	Quality Improvement

TABLE VIII. FISCAL YEAR 1978 - TITLE IV-A SUPPORTED PROJECTS--Continued

State	Grantee	Project Title	Amount	Category
New York	New York University	Improving Medical School Curriculum for Health Care of the Nation's Elderly	$ 82,920	Quality Improvement
	State University at Albany	Support for Career Training in Aging	102,393	Career
	City University of New York	Research Training Program in Urban Gerontology	108,695	Career
	State University of New York at Buffalo	Career Training	126,681	Career
	Syracuse University	Multifaceted Training in Gerontology	199,980	Career
	Syracuse University	Integrated Mid-Career Training for Practitioners in Selected Programs for the Elderly	40,769	Quality Improvement
	Office for the Aging	State Title IV-A Training	521,254	
North Carolina	Duke University Center for the Study of Aging	KWIC Training Resources in Aging Project	136,086	Quality Improvement
	Livingstone College	All College Gerontology Concentration	59,342	Career
	Duke University Medical Center	Multidisciplinary Training in Geriatric Care	58,692	Career
	Wayne Community College	Geriatric Technician Training Program	45,370	Career
	Governor's Coordinating Council on Aging	State Title IV-A Training	128,990	
North Dakota	Aging Services	State Title IV-A Training	30,000	

TABLE VIII. FISCAL YEAR 1978 - TITLE IV-A SUPPORTED PROJECTS--Continued

State	Grantee	Project Title	Amount	Category
Ohio	Case Western Reserve University	Specialization in Aging	$101,325	Career
	Wright State University	Gerontology/Geriatric Educational Program	82,217	Career
	Scripps Foundation Gerontology Center, Miami University	Career Education and Training at Miami University	61,617	Career
	The University of Akron	Career Training in Adult Development and Aging	46,950	Career
	Commission on Aging	State Title IV-A Training	272,484	
Oklahoma	Special Unit on Aging	State Title IV-A Training	82,643	
Oregon	Portland State University	Serving the Nation's Elderly: Multidisciplinary Training in the Field of Aging	165,904	Career
	Oregon State University	Career Training in Aging	104,909	Career
	University of Oregon	A Multidisciplinary Center for Gerontology	125,206	Career
	Program on Aging	State Title IV-A Training	66,006	
Pennsylvania	The Pennsylvania State University	Career Training Program in Aging	154,106	Career
	Office of Aging	State Title IV-A Training	354,978	
Puerto Rico	Gericulture Commission	State Title IV-A Training	53,021	
Rhode Island	Division on Aging	State Title IV-A Training	30,000	
South Carolina	Commission on Aging	State Title IV-A Training	60,661	

TABLE VIII. FISCAL YEAR 1978 - TITLE IV-A SUPPORTED PROJECTS--Continued

State	Grantee	Project Title	Amount	Category
South Dakota	Office on Aging	State Title IV-A Training	$ 30,000	
Tennessee	Fisk University	Graduate Masters of Art Program in Gerontology	70,620	Career
	Middle Tennessee State University	Multidisciplinary Gerontology Program	37,947	Career
	Commission on Aging	State Title IV-A Training	112,307	
Texas	Governor's Committee on Aging	State Title IV-A Training	295,319	
	North Texas State University	Multidisciplinary Career in Aging	123,106	Career
	University of Texas at Arlington	Chicano Aging Administration Training Program	97,307	Career
	Our Lady of the Lake University of San Antonio	Chicano Aging Program	67,491	Career
	Houston Tillotson College	Gerontology Project to Establish a Multidisciplinary Program	69,417	Career
	Prairie View A&M University	Multidisciplinary Undergraduate Career Training Program Specializing in Rural Gerontology	71,874	Career
	The University of Texas at Austin	Multidisciplinary Studies in Aging	113,267	Career
Utah	Rocky Mountain Gerontology Center-University of Utah	Rocky Mountain Gerontology/Training Program-Career Training	239,919	Career
	Division of Aging	State Title IV-A Training	30,000	

TABLE VIII. FISCAL YEAR 1978 - TITLE IV-A SUPPORTED PROJECTS--Continued

State	Grantee	Project Title	Amount	Category
Vermont	Office on Aging	State Title IV-A Training	$ 30,000	
Virginia	Hampton Institute	Under Graduate Interdisciplinary Career Training in Gerontology	35,493	Career
	Virginia Union	Multidisciplinary Gerontology Minor Program	102,336	Career
	Norfolk State College	Interdisciplinary Expansion of Gerontology Training Program	44,994	Career
	Virginia Commonwealth University	Multidisciplinary Career Training in Aging	107,944	Career
	Office on Aging	State Title IV-A Training	111,688	
Virgin Islands	Commission on Aging	State Title IV-A Training	15,000	
Washington	Office on Aging	State Title IV-A Training	92,163	
West Virginia	West Virginia University	Social Work Career Training Program in Aging	57,697	Career
	Commission on Aging	State Title IV-A Training	54,302	
Wisconsin	University of Wisconsin	Career Training - Expansion of Interdisciplinary Components of Training in Gerontology	173,007	Career
	Division on Aging	State Title IV-A Training	128,458	
Wyoming	University of Wyoming	Social Work Education - Aging	20,474	Career
	Aging Services	State Title IV-A Training	30,000	

7. RESEARCH AND DEVELOPMENT PROGRAM

a. Support for Policy/Advocacy and Service System Development

The research and development program seeks to build and expand knowledge in the field of aging critical to the development and implementation of policies, programs, and services beneficial to older persons. Since its beginning under Title IV of the Older Americans Act, the research program has been directed toward supporting AoA's legislatively mandated programs and responsibilities. Under this directed research approach, the program has a dual focus on research in support of policy/advocacy and research to foster development of community-based service systems.

Policy/advocacy research projects examine public and private policies and issues which have significant impact on the lives of older persons relative to employment, retirement, income, housing, health, and services. Research results are used to recommend new,or modifications of existing,policies to improve the life circumstances of older people. Research focusing on issues related to service system development places emphasis on services to sustain vulnerable older persons in their own homes or in the least restrictive care setting appropriate to their needs. Results of this research are used to assist in the design and implementation of service programs which will contribute to the establishment of a comprehensive continuum of services at the community level.

b. Program Activities

Of the $8.5 million available to the Title IV, Part B research and development program in FY 1978, $5.0 million funded new projects. Twenty-seven (27) new grants were awarded for policy/advocacy projects. These projects deal with issues such as employment opportunities and training programs for older workers, impact of eliminating mandatory retirement, adequacy of the private pension system, allocation of Title XX resources, private health insurance supplementation for Medicare, and the incidence of maltreatment of older persons.

New grants of $2.4 million were awarded for twenty-one (21) projects related to the development of community-based long-term care systems for the more vulnerable elderly. These projects examine such issues as improving selection of care alternatives, availability and cost of domiciliary care, the cost benefits of alternative service/treatment modalities, long-term care needs of the rural aged, and the benefits of geriatric hospital day care.

Additionally, $.2 million was designated to support a project as part of another AoA program to develop increased capacity of minority researchers in the field of aging.

Tables IX and X provide detailed information on these awards.

TABLE IX. TITLE IV-B FUNDING SUMMARY (FY 1975-1978)

	Approximate Amount	No. Projects
Fiscal Year 1975 - $7.0 million		
Policy/Advocacy	$0.9 million	8
Service Systems	$4.5 million	38
Other*	$1.6 million	19
Fiscal Year 1976 and Transition Quarter - $10.0 million		
Policy/Advocacy	$1.8 million	25
Service Systems	$6.8 million	60
Other*	$1.4 million	13
Fiscal Year 1977 - $8.5 million		
Policy/Advocacy	$0.5 million	8
Service Systems	$6.1 million	55
Other*	$1.9 million	7
Fiscal Year 1978 - $8.5 million		
Policy/Advocacy	$2.7 million	29
Service Systems	$5.6 million	38
Other*	$0.2 million	1

---

*Depending on the year, balances include other items such as interagency agreements, taps, and interprogram transfers as well as projects which cut across both types of research.

TABLE X. FISCAL YEAR 1978 RESEARCH AND DEVELOPMENT PROJECTS
(TITLE IV, PART B, OLDER AMERICANS ACT OF 1965, AS AMENDED)

THE NEEDS OF THE OLDER PERSON AND CONDITIONS WHICH AFFECT THESE NEEDS

New Awards

National Indian Council on Aging (Juana Lyon) Albuquerque, New Mexico	"Program Research for Serving the Indian Elderly"	$149,821
The Urban Institute (Jeffrey Koshel, Michael Gutowski) Washington, D.C.	"The Impact of Suburbanization and the Needs of Older Persons"	$ 85,993

Ongoing Projects

University of Southern California (Stephen McConnell) Los Angeles, California	"A Comparative Applied Study of Health Retirement and Housing Issues Affecting Mexican-American, Black, and White Elderly"	$184,682
Asociacion Nacional Pro Personas Mayores (Carmela Lucayo) Los Angeles, California	"A National Study to Assess the Service Needs of the Hispanic Elderly"	$120,663
The Urban Institute (Richard Wertheimer) Washington, D.C.	"Forecasting the Changes in the Characteristics of Older Persons Between Now and 1990"	___[1/]
Georgetown University (Beth Soldo) Washington, D.C.	"Cohort Composition and Changes in the Elderly Population 1975-1990"	___[1/]

[1/] No FY 1978 funds were awarded projects for which no amounts are given in this table; these projects operated on funds awarded in previous fiscal years.

TABLE X. FISCAL YEAR 1976 RESEARCH AND DEVELOPMENT PROJECTS (TITLE IV, PART B, OLDER AMERICANS ACT OF 1965, AS AMENDED)--Continued

THE NEEDS OF THE OLDER PERSON AND CONDITIONS WHICH AFFECT THESE NEEDS--Continued

Ongoing Projects--Continued

University of Miami (Herbert Quay) Miami, Florida	"The Economic, Social and Psychological Impacts on the Elderly Resulting From Criminal Victimization"	$157,072
University of Southern California (Judith Treas) Los Angeles, California	"Aged and Pre-Aged Women: Analysis of Needs (Successful Work Options of Aging Women)"	$ 12,137
American Institutes for Research (John Flanagan) Palo Alto, California	"Identifying Opportunities for Improving the Quality of Life of Older Age Groups"	—
University of Georgia (James Dowd) Athens, Georgia	"Socialization to Old Age in an Urban Setting"	—
University of Illinois, Chicago Circle (Ethel Shanas) Chicago, Illinois	"National Survey of the Aging"	$ 67,249
University of Maryland (Margaret Gatz) College Park, Maryland	"Aging Competency"	—
University of Missouri-Columbia (Robert Habenstein) Columbia, Missouri	"Local Socio-Environmental Contexts and Personal Moorings Related to Decision-Making and the Elderly"	—
Duke University (George Myers) Durham, North Carolina	"Changing Household Patterns Among the Elderly"	
Duke University (Martin Lakin) Durham, North Carolina	"Group Behavior and Socialization Experiences"	—
University of Pittsburgh (Gerald Zaltman) Pittsburgh, Pennsylvania	"Consumerism and the Aging: The Elderly as Victims of Fraud"	—

TABLE X. FISCAL YEAR 1978 RESEARCH AND DEVELOPMENT PROJECTS (TITLE IV, PART B, OLDER AMERICANS ACT OF 1965, AS AMENDED)--Continued

THE NEEDS OF THE OLDER PERSON AND CONDITIONS WHICH AFFECT THESE NEEDS--Continued

Ongoing Projects--Continued

Battelle Human Affairs Research Center (Herbert Edelherts) Seattle, Washington	"Consumerism and the Aging: The Elderly as Victims of Fraud"	---
Regents of the University of Michigan (Harold Johnson) Ann Arbor, Michigan	"American Values and the Elderly"	$ 92,403
University of Pennsylvania (George Gerbner, Larry Gross and Nancy Signorielli) Philadelphia, Pennsylvania	"Aging With Television"	$116,619

INFORMAL SUPPORTS

Ongoing Projects

San Diego State University (Percil Stanford) San Diego, California	"The Servidor System"	---
American Institutes for Research (Sara Rix) Washington, D.C.	"With a Little Help From My Friends"	$132,818
National Center for Black Aged (Wilbur Watson) Washington, D.C.	"Informal Social Networks in Support of Elderly Blacks in the Black Belt of the United States"	$146,000
University of Illinois, Chicago Circle (Masako Osako) Chicago, Illinois	"Aging, Social Isolation, and Kinship Ties Among Japanese-Americans"	$ 50,812
Massachusetts Institute of Technology (Sandra Howell) Cambridge, Massachusetts	"New Community: A Documented History of a Congregate Residence"	---
Hebrew Rehabilitation Center for Aged (Sylvia Sherwood) Boston, Massachusetts	"A Study of the Informal Support Network of the Needy Elderly"	$220,000

TABLE X. FISCAL YEAR 1978 RESEARCH AND DEVELOPMENT PROJECTS (TITLE IV, PART B, OLDER AMERICANS ACT OF 1965, AS AMENDED)--Continued

INFORMAL SUPPORTS--Continued

Ongoing Projects--Continued

Fordham University (Marjorie Cantor) Brooklyn, New York	"The Impact of the Entry of the Formal Organizations on Existing Networks of Older Americans"	----
Philadelphia Geriatric Center (Elaine Brody) Philadelphia, Pennsylvania	"The Dependent Elderly and Women's Changing Role"	$122,170
Catholic University of America (David Guttman) Washington, D.C.	"Informal Social Networks and Assistance Among the Elderly"	$ 30,156
Bowman Gray School of Medicine, Wake Forest University Winston-Salem, North Carolina	"Incentives and Family Environments for the Elderly"	----
The Mitre Corporation (John Chester) McLean, Virginia	"Technology in the Services of the Aged Through the Retirement Cooperative Concept"	----

PROVISION OF SERVICES

Ongoing Projects

University of Kansas (Walter Crockett) Lawrence, Kansas	"Attitudes Towards Older Persons on the Part of Service Delivery Professionals"	----
Special Services for Groups, Inc. (Sharon Fujii) Los Angeles, California	"Service Delivery Models for Pacific Asian Elderly"	$ 70,349
Division of Youth and Family Services Department of Institutions and Agencies, State of New Jersey (George Dannenberg) Trenton, New Jersey	"The Utilization of the Elderly in Child Welfare Services"	----
Portland State University (Douglas Montgomery) Portland, Oregon	"Attitudes Towards Older Persons on the Part of Services Delivery Professionals"	----

TABLE X. FISCAL YEAR 1978 RESEARCH AND DEVELOPMENT PROJECTS (TITLE IV, PART B, OLDER AMERICANS ACT OF 1965, AS AMENDED)--Continued

PROVISION OF SERVICES--Continued

Ongoing Projects--Continued

Portland State University (Terrie Wetle) Portland, Oregon	"Analysis of Coordination and Organization Change"	----
The Institute of Public Administration (Joseph Revis) Washington, D.C.	"Information Dissemination Models on Transportation Services for Older Americans"	$ 66,694
University of Southern California (Raymond Steinberg) Los Angeles, California	"Alternative Designs for Comprehensive Service Delivery to the Elderly Through Case Service Coordination/Advocacy"	$256,775
Foundation of California State University, Sacramento Sacramento, California	"Techniques of Social Service Provision to the Minority Aged"	----
County of Los Angeles Area Agency on Aging (Victor Regnier) Los Angeles, California	"Community Analysis Techniques"	$ 7,709
University of Miami (Jose Szapocanik) Miami, Florida	"Reaching Out to the Hispanic Elderly"	----
Wayne State University (Charles Omarzu) Detroit, Michigan	"An Investigation of the Feasibility of a Computerized Model of the Provision of Services to the Elderly"	----
Regents of the University of Michigan (Harold Johnson) Ann Arbor, Michigan	"Home Health Care Among Black Elderly"	----
State of Washington Department of Social and Health Services (Gary Johnson) Olympia, Washington	"Models of Case Coordination for Provision of Services to the Elderly'	----

TABLE X. FISCAL YEAR 1978 RESEARCH AND DEVELOPMENT PROJECTS (TITLE IV, PART B, OLDER AMERICANS ACT OF 1965, AS AMENDED)—Continued

SERVICE DELIVERY SYSTEMS

New Awards

Center for Public Management (Robert Stross) Potomac, Maryland	"Differences in Delivery of Services in States With and Without Area Agencies"	$108,545
Health Systems Planning Foundation of Suffolk (Henry Brill) Stony Brook, New York	"Role of SUAs and AAAs in Provision of Services to the Deinstitutionalized Elderly"	$ 95,925
TARP Institute (Arthur Boyd) Washington, D.C.	"Techniques for Developing Political Support for the Aging"	$125,000

Ongoing Projects

Regents of the University of California, Sacramento (Carroll Estes) San Francisco, California	"Funding Practices, Policies, and Performance of State and Area Agencies on Aging"	$340,875
Scientific Analysis Corporation (Neil Gilbert, Harry Specht) San Francisco, California	"An Analysis of the Implications of Title XX Service Plans for the Nationwide Development of Local Comprehensive Service Delivery Systems for the Aged"	——
Institute for Economic and Social Measurements, Inc. (Jon Burnhardt) Bethesda, Maryland	"Analysis of the Continuation of Services Funded Under Title III"	$ 75,281
Pennsylvania State University (George Kleindorfer, Frederick Eiselle) University Park, Pennsylvania	"Simulating Demand and Costs for Statewide Services to the Aging"	——

TABLE X. FISCAL YEAR 1978 RESEARCH AND DEVELOPMENT PROJECTS (TITLE IV, PART B, OLDER AMERICANS ACT OF 1965, AS AMENDED)--Continued

LONG-TERM CARE

New Awards

Hebrew Rehabilitation Center for Aged Department of Social Gerontological Research (Sylvia Sherwood) Roslindale, Massachusetts	"Paths to Alternative Services Modalities and Differential Impact of These Modalities on Similar Groups of Vulnerable Elderly"	$189,129
Hunter College jointly with the Research Foundation of CUNY (Rose Dubrof & Barbara Morrison) New York, New York	"The Path to the Institution: Sociocultural, Familial, and Organizational Factors"	$ 97,034
Brandeis University Levinson Policy Institute Florence Heller Graduate School for Advanced Studies in Social Welfare (Alan Sager, Robert Morris) Waltham, Massachusetts	"Decision-Making for Home Care"	$169,835
Georgetown University (Beth Soida) Washington, D.C.	"Long-Term Care Decision Making: Institutionalized Elderly"	$113,778
Hebrew Rehabilitation Center for Aged Department of Social Gerontological Research (Sylvia Sherwood) Roslindale, Massachusetts	"What is the Availability and Cost of Domiciliary Care and What Services are Provided in Such Supportive Residential Settings for Older Persons"	$157,769
Columbia University (Barry Gurland, Anthony Mann, Ruth Bennett and David Wilder) New York, New York	"A Cross-National Study of the Cost-Benefits of Alternative Service Treatment Modalities for Older Persons"	$218,138
Community Research Applications, Inc. (Douglas Holmes) Weston, Connecticut	"The Cost Effect and Benefits Associated With Daycare, Day Hospitals Domiciliary Care, Intermediate Care, and Skilled Nursing Care"	$165,110

TABLE X. FISCAL YEAR 1978 RESEARCH AND DEVELOPMENT PROJECTS (TITLE IV, PART B, OLDER AMERICANS ACT OF 1965, AS AMENDED)--Continued

LONG-TERM CARE--Continued

New Awards--Continued

University of Pennsylvania Center on Aging (Sharon Simson, Laura Bleiweiss) Philadelphia, Pennsylvania	"Establishing a Data Base on Emergency Services and the Elderly: Planning for Linkages Between Emergency Services, Long-Term Care, and Health Related Services"	$149,494
Health Systems Agency of Northeastern New York (J. Stanley Yake, Eleanor Stroller) Albany, New York	"Aging as a Rural Phenomenon"	$139,996
Georgetown University (David Rabin) Washington, D.C.	"Maintaining the Elderly in the Community"	$106,831
Wake Forest University (Marvin Sussman) Winston-Salem, North Carolina	"Models for Elderly Home Care"	$ 90,400
Foundation of the American College of Nursing Home Administrators (Suzanne Wood) Washington, D.C.	"Nursing Homes and the Black Elderly: Utilization and Satisfaction"	$ 65,045
The Urban Institute (William Scanlon) Washington, D.C.	"Models of the Utilization and Cost of Long-Term Care Services"	$ 71,947
University of Pennsylvania (Walter Poulshock) Philadelphia, Pennsylvania	"Assessment of Geriatric Day Hospital Care"	$ 98,259

Ongoing Projects

Minnesota Board on Aging (Nancy Anderson) Minneapolis, Minnesota	"Comparison of In-Home and Nursing Home Care for Older Persons in Minnesota"	$114,899

TABLE X. FISCAL YEAR 1978 RESEARCH AND DEVELOPMENT PROJECTS (TITLE IV, PART B, OLDER AMERICANS ACT OF 1965, AS AMENDED)--Continued

LONG-TERM CARE--Continued

Ongoing Projects--Continued

Research Foundation for Mental Hygiene (Barry Gurland) Albany, New York	"A Cross-National Comparison of the Institutional Elderly: Including Costs, Quality, and Outcome of Their Long-Term Care	—
Brandeis University (Robert Morris, Alan Sager) Waltham, Massachusetts	"Approaches to Determining the Cost of Home Care Alternative to Nursing Home Care: The Diversion Strategy"	—

EMPLOYMENT

The American University (Bradley Schiller) Washington, D.C.	"Private Pension and Employment Opportunities"	$ 74,207
Appalachian State University Bureau of Economic and Business Research (Jean-Pierre A. Courbois, Michael McDonough) Boone, North Carolina	"Impact of Public Employment and Training Programs on Older Workers"	$ 74,677
The Urban Institute (Nancy M. Gordon) Washington, D.C.	"A Cross-National Study of Part-time Employment for the Elderly"	$ 81,644
The American University (Bradley Schiller) Washington, D.C.	"Private Pension Plans and the Older Worker - Further Analysis"	$ 71,967

Ongoing Projects

American Institutes for Research (Harold Sheppard) Washington, D.C.	"Impact of Unemployment Climate on Older Workers in Two Labor Markets With Contrasting Unemployment Rates"	—
University of Virginia (William Serow) Charlottesville, Virginia	"Implications of Prospective Population Change for Older American Workers"	—

TABLE X. FISCAL YEAR 1978 RESEARCH AND DEVELOPMENT PROJECTS (TITLE IV, PART B, OLDER AMERICANS ACT OF 1965, AS AMENDED)--Continued

EMPLOYMENT--Continued		
Ongoing Projects--Continued		
Human Resources Research Organization (Thurlow Wilson) Arlington, Virginia	"Analysis of Employment Services for Older Job Seekers"	—
RETIREMENT		
New Awards		
The University of North Carolina (Benson Rosen, Thomas H. Jerdee) Chapel Hill, North Carolina	"An Investigation of the Retirement Decision Process"	$ 99,990
The Urban Institute (Richard Wertheimer) Washington, D.C.	"The Direct and Indirect Consequences of Increasing or Eliminating the Mandatory Retirement Age"	$ 58,865
North Carolina State University (Robert Clark, David Baker and Steven Cantrell) Raleigh, North Carolina	"Outlawing Age Discrimination: Economic and Institutional Responses to the Elimination of Mandatory Retirement"	$ 69,383
Portland State University Institute on Aging (Elizabeth Meire, Douglas Montgomery, Lois Keast, Eileen Jean and Gary Holznagel) Portland, Oregon	"Retirement Age Policies and Employment Opportunities"	$ 60,000
INCOME		
New Awards		
The Urban Institute (Gary Hendricks, Michael Arthur) Washington, D.C.	"The Adequacy of Earnings Replacement Through Private Pensions"	$ 71,136

TABLE X. FISCAL YEAR 1978 RESEARCH AND DEVELOPMENT PROJECTS (TITLE IV, PART B, OLDER AMERICANS ACT OF 1965, AS AMENDED)--Continued

HOUSING

New Awards

Community Research Applications, Inc. (Monica Holmes) Weston, Connecticut	"The Planning and Impact of Service-Rich Publicly-Supported Housing for Older Persons"	$ 73,878
Philadelphia Geriatric Center (M. Powell Lawton) Philadelphia, Pennsylvania	"Federal Housing Services to Community-Resident Elderly"	$ 81,109
Portland State University School of Urban Affairs Institute on Aging (Byron Walters, Leon Cain) Portland, Oregon	"A Minority Group Research Project - The Impact of Rehabilitation, Repair and Maintenance Programs on Elderly Homeowners: A Three-City Study of Minority and non-Minority Differentials"	$ 82,477
The Urban Institute (Neil Mayer) Washington,, D.C.	"Assessment of the Adequacy of Federal Home Maintenance and Repair Loan or Grant Programs in Meeting the Needs of Elderly Homeowners"	$ 74,349
Fall River Housing Authority Special Studies for Independent Living (Sylvia Sherwood) Fall River, Massachusetts	"A Study of Special Housing Needs of Diverse Groups of Chronically Ill and Physically Impaired Elderly"	—

Ongoing Projects

Philadelphia Geriatric Center (M. Powell Lawton) Philadelphia, Pennsylvania	"The Elderly and Their Housing"	$120,781

TABLE X. FISCAL YEAR 1978 RESEARCH AND DEVELOPMENT PROJECTS (TITLE IV, PART B, OLDER AMERICANS ACT OF 1965, AS AMENDED)—Continued

HEALTH		
New Awards		
University of California, Berkeley (Shaw, Minkler, Rosow, and Sholtz) Berkeley, California	"Investigation of the Effects of Retirement on the Utilization of Health Services: An Examination of the Factors which Affect the Utilization of Health Services after Retirement"	$ 83,751
The American University (Harold Herman) Washington, D.C.	"Medicare Supplements: Their Value and Control"	$ 97,297
Ongoing Projects		
The Urban Institute (John Holahan) Washington, D.C.	"The Development of an AoA Strategy for Policy Research in Aging: Health and the Elderly"	$ 13,393
SOCIAL SERVICES		
New Awards		
Community Research Application, Inc. (Douglas Holmes, Monica Holmes) Weston, Connecticut	"Changes in the Allocation of Service Resources and in the Coverage Provided to Older Persons Most in Need of Services Under Title XX"	$121,441
Scientific Analysis Corporation (Neil Gilbert, Harry Specht) San Francisco, California	"Services to the Elderly Under Title XX: An Analysis of National Trends 1975-1979"	$ 86,505
Michigan State University Dept. of Community Health Science (Sidney Katz, Joseph Papsidero) East Lansing, Michigan	"Policy Research in Long-Term Care"	$ 95,814

TABLE X. FISCAL YEAR 1978 RESEARCH AND DEVELOPMENT PROJECTS (TITLE IV, PART B, OLDER AMERICANS ACT OF 1965, AS AMENDED)—Continued

CROSSCUTTING ISSUES/MINORITY BENEFITS		
San Diego County - Area Agency on Aging (M. Gene Aldridge) San Diego, California	"Minority Elderly Americans: Development of Prototype for Area Agencies on Aging in the Assessment of Equitability for Receipt of Public Benefits in Housing, Employment, Retirement Income, Health and Services"	$203,571
The Institute for the Study of Human Systems, Inc. (Robert Creacy, Solomon Jacobson) Columbia, Maryland	"Equal Opportunity for Minority Elderly: An Inquiry"	$ 94,342
The Catholic University of America (David Guttmann) Washington, D.C.	"Perspective on Equitable Share of Public Benefits by the Elderly in Minority Groups"	$110,016
Foundation of California State University, Sacramento (Jesse F. McClure) Sacramento, California	"The Minority Elderly: 'Equal Opportunity' Myth or Reality?"	$151,757
CROSSCUTTING ISSUES/ADVOCACY		
University of Maryland Center on Aging (Marilyn R. Block) College Park, Maryland	"The Battered Elder Syndrome: An Exploratory Study"	$ 95,941
The University of Michigan Institute of Gerontology (Richard Douglas, Tom Hickey) Ann Arbor, Michigan	"Maltreatment and Abuse of the Elderly Incidence and Program Model"	$100,130
Florida State University (Winsor Schmidt, William Bell, Kent Miller) Tallahassee, Florida	"Public Guardianship and the Elderly	$ 84,904

TABLE X. FISCAL YEAR 1978 RESEARCH AND DEVELOPMENT PROJECTS (TITLE IV, PART B, OLDER AMERICANS ACT OF 1965, AS AMENDED)--Continued

CROSSCUTTING ISSUES/ADVOCACY--Continued

Northern Illinois University (Douglas Dobson) Dekalb, Illinois	"The Political Impact of Elderly"	$ 95,573

Ongoing Projects

The Urban Institute (Jeffrey Koshel, Eugene Durman) Washington, D.C.	"Client Oriented Community - Assessment of Long-Term Care Facilities"	$206,208
Northern Illinois University (Douglas Dobson) Dekalb, Illinois	"Development and Adoption of Policies for The Elderly: The State Legislative Process"	—

RESEARCH DEVELOPMENT

New Awards

University of Missouri (Warren Peterson) Kansas City, Missouri	"Implementation and Utilization of a Research Instrument Bank in Aging"	$121,000
Regents of the University of Michigan (Jerome Clubb, Harold Johnson) Ann Arbor, Michigan	"Data Archives, Training and Consultation Services in the Field of Aging"	$158,038

8. MULTIDISCIPLINARY CENTERS OF GERONTOLOGY

Title IV, Part E of the Older Americans Act authorizes the Commissioner on Aging to make grants to public and private non-profit organizations and institutions to establish or support multidisciplinary centers of gerontology. The functions of a multidisciplinary center of gerontology are to:

- recruit and train personnel at the professional and subprofessional levels;
- conduct basic and applied research on work, leisure, and education of older people, living arrangements of older people, the economics of aging, and other related areas;
- provide consultation to public and voluntary organizations with respect to the needs of older people and in planning and developing services for them;
- serve as repositories of information and knowledge with respect to the areas for which it conducts basic and applied research;
- stimulate the incorporation of information on aging into the teaching of biological, behavioral, and social sciences in colleges or universities;
- help to develop training programs on aging in schools of social work, public health, health care administration, education, and in other such schools at colleges and universities; and
- create opportunities for innovative, multidisciplinary efforts in training, research, and demonstration projects relating to aging.

The Title IV, Part E Multidisciplinary Center of Gerontology program provides for grants under two different categories:

(1) developmental grants to support the establishment of multidisciplinary centers, or alternatively to assist recently established institutes on aging in realizing their potential for becoming Multidisciplinary Centers of Gerontology.

(2) operational grants to already well-established multidisciplinary centers of gerontology to expand and strengthen their activities consistent with the provisions of Title IV, Part E.

Table XI provides details on these grants.

TABLE XI. ADMINISTRATION ON AGING MULTIDISCIPLINARY CENTERS OF GERONTOLOGY FISCAL YEAR 1978

I. CONTINUATION AWARDS

a. Developmental Grants (for grantees who were first funded in FY 1976)

	Grantee Organization	Program Director	Award
(1)	Florida State University Tallahassee, Florida 32306	William G. Bell	$45,036
(2)	North Country Community College Saranac Lake, New York 12983	James M. Bellis	48,025
(3)	University of Pennsylvania Philadelphia, Pennsylvania 19104	Patrick B. Storey	65,235
(4)	University of Illinois at Chicago Circle Chicago, Illinois 60680	Thomas O. Byerts	56,396
(5)	University of Iowa Iowa City, Iowa 52240	Thomas H. Walz	56,885
(6)	University of Hawaii Manoa Campus Honolulu, Hawaii 96822	Richard K. C. Lee	79,198
(7)	University of Connecticut Storr, Connecticut 06268	Howard A. Rosencranz	45,177
(8)	University of Alabama in Birmingham-Center for Aging Birmingnam, Alabama 35294	Howard W. Schnaper	63,564
(9)	City University of New York New York, New York 10036	Neil G. McCluskey	63,719
(10)	The University of Alabama University, Alabama 35486	Lorin A. Baumhover	45,571
(11)	University of Miami Coral Gables, Florida 40306	Priscilla R. Perry	57,845
(12)	University of Kentucky Lexington, Kentucky 40306	David R. Wekstein	32,042

TABLE XI. ADMINISTRATION ON AGING MULTIDISCIPLINARY CENTERS OF GERONTOLOGY, FISCAL YEAR 1978--Continued

b. Operational Grants (for grantees who were first funded in FY 1976)

	Grantee Organization	Program Director	Award
(1)	Syracuse University New York, New York 13210	Walter Beattie, Jr.	$141,977
(2)	University of Southern California Los Angeles, California 90007	James E. Birren	142,240
(3)	Pennsylvania State University University Park, Pennsylvania 16802	Joseph Britton	128,684
(4)	Duke University Durham, North Carolina 27706	George L. Maddox	145,881
(5)	North Texas State University Denton, Texas 76203	H. J. Friedsam	119,631
(6)	Miami University Oxford, Ohio 45056	Robert C. Atchley	62,889
(7)	Boston University Boston, Massachusetts 02215	Knight Steel Paul M. Gertman	123,695

II. CONTINUATION AWARDS

a. Developmental Grants (for grantees who were first funded in FY 1977)

	Grantee Organization	Program Director	Award
(1)	University of Louisville Louisville, Kentucky 40208	Barbara R. Bradshaw	$68,000
(2)	Temple University Philadelphia, Pennsylvania 19122	Richard C. Adelman	57,000
(3)	San Diego State University San Diego, California 92182	E. Percil Stanford	59,949
(4)	University of Pittsburgh Pittsburgh, Pennsylvania 15261	Barbara K. Shore Edmund Ricci	58,228
(5)	University of Oregon Eugene, Oregon 97403	Frances Gillespie Scott	56,000
(6)	University of Minnesota Minneapolis, Minnesota 55455	Frank Lassman	62,308
(7)	State University of New York at Albany Albany, New York 12201	Susan R. Sherman	64,967

TABLE XI. ADMINISTRATION ON AGING MULTIDISCIPLINARY CENTERS OF GERONTOLOGY, FISCAL YEAR 1978--Continued

	Grantee Organization	Program Director	Award
(8)	The University of Akron Akron, Ohio 44325	Harvey L. Stearns	$59,000
(9)	University of Nebraska at Omaha Omaha, Nebraska 68101	Christopher Bolton	60,030
(10)	Hampton Institute Hampton, Virginia 23668	Juanita F. Strawn	55,000
(11)	Wichita State University Wichita, Kansas 67208	William C. Hays	69,100
(12)	Virginia Commonwealth University Richmond, Virginia 23220	Gregory Arling	63,000
(13)	University of Puerto Rico San Juan, Puerto Rico 00936	Belarmina Morales de Rivera	58,000
(14)	University of Kansas Lawrence, Kansas 66045	Walter H. Crockett	53,680
(15)	West Virginia University Morgantown, West Virginia 26505	Anita S. Harbert	50,992
(16)	Hamline University St. Paul, Minnesota 55104	Chung-Tai Lu	30,253

b. Operational Grants (for grantees who were first funded in FY 1977)

	Grantee Organization	Program Director	Award
(1)	University of Missouri Columbia, Missouri 65201	Donald I. Cowgill	$131,899
(2)	Hunter College New York, New York 10021	Rose Dobrof	132,741
(3)	University of Wisconsin Madison, Wisconsin 53706	Martin B. Loeb	129,071
(4)	Philadelphia Geriatric Center Philadelphia, Pennsylvania 19141	Powell Lawton	149,058
(5)	University of Michigan Ann Arbor, Michigan 48109	Harold R. Johnson	128,836
(6)	University of Washington Seattle, Washington 98195	Carl Eisdorfer	130,325
(7)	Portland State University Portland, Oregon 97207	Douglas Montgomery	132,000
(8)	Wayne State University Detroit, Michigan 48202	Charles J. Parrish	132,232

9. MODEL PROJECTS PROGRAM

During FY 1978, Title III, Section 308 of the Older Americans Act authorized the Commissioner to make grants to any public or non-profit private agency or contracts with any organization for model projects which promote the well-being of older persons. Model projects were designed to demonstrate ways of improving and expanding services for older persons by testing innovative approaches and new initiatives. During FY 1978, program priority areas were stated in the Older Americans Act as follows:

1. Housing and living arrangements
2. Continuing education
3. Preretirement education, information, and relevant services
4. Special services to mentally and physically impaired older persons
5. Ombudsman services for residents of nursing homes
6. Improved services to underserved older persons, with emphasis upon the needs of low income, minority, Indian, limited English-speaking, and rural elderly
7. Senior ambulatory care day centers and other types of assistance to older persons to remain out of institutions and to maintain independent living.

A summary of Model Projects awards during the fiscal years 1974 through 1978 follows.

Model Projects on Aging Program

Fiscal Year 1974 - $11 million

State grants for general development	$6.3 million	50 awards
Evaluation of Title III	1.0 million	
Demonstration Projects	3.7 million	40 awards

Fiscal Year 1975 - $7.3 million

Legal Service Demonstrations	$1,193,259	11 awards
Other Demonstrations	6.1 million	52 awards

Fiscal Year 1976 and Transition Quarter - $14.5 million

Legal Service Demonstrations	$1,248,963	10 awards
State Nursing Home Ombudsman	1.5 million	52 awards
Other Demonstrations	11.8 million	72 awards

Fiscal Year 1977 - $12 million

State grants for Nursing Home Ombudsman	$ .4 million	15 awards
State grants for Legal Services	1.2 million	50 awards
Demonstrations on Crime	1.0 million	6 awards
Senior Environmental Protection Demonstrations	1.0 million	10 awards
Other Demonstrations	8.4	50 awards

Fiscal Year 1978 - $15,497 million

State Legal Service Grants	$ 2.420 million	50 awards
State Nursing Home Ombudsman	1.050 million	49 awards
Other Demonstrations	12.022 million	44 new awards 50 continuations

The 44 new Model Project awards during FY 1978 are summarized in Table XII.

TABLE XII. NEW MODEL PROJECTS FUNDED WITH FY 1978 FUNDS

Hospice of the Valley, Inc.
"C.O.R.E. System Response"
908 North 24th Street
Phoenix, Arizona 85008
$116,850

University of Arizona
Department of Public
Administration & Psychology
"Evaluation of Hillhaven Hospice"
Tucson, Arizona 85721
$70,000

Pima County Board of Supervisors
"Community Services System"
131 West Congress
Tucson, Arizona 85701
$244,748

Arkansas Office on Aging
Division of Department of
Human Services
"Service Management Project"
7107 West 12th Street
Post Office Box 2179
Little Rock, Arkansas 72203
$201,000

Foundation for Comprehensive
Health Services, Inc.
"A Model Medical and Health
Care System"
Post Office Box 22697
Sacramento, California 95822
$132,300

Santa Monica Hospital
Medical Center
Center for the Partially Sighted
"Comprehensive Community Care
System"
1225 15th Street
Santa Monica, California 90404
$179,890

Commission on Community Relations
"Advocacy for Senior Consumers"
431 West Colfax Avenue
Denver, Colorado 80204
$100,000

State of Connecticut
Department on Aging
Community Care Systems
90 Washington Street
Hartford, Connecticut 06115
$227,078

National Council on the Aging, Inc.
"Senior Centers Y Community Care"
1828 L Street, N.W., Suite 504
Washington, D.C. 20036
$80,951

Center for Gerontological Studies
"Alternative Living Arrangements
for the Elderly"
221 Matherly Hall
Gainesville, Florida 32611
$66,299

Aging & Adult Services Program
"Community Care System"
1321 Winewood Boulevard
Tallahassee, Florida 3230
$56,323

Malama Makua
"Treatment & Rehabilitation
Center for Handicapped"
296 North Vineyard
Honolulu, Hawaii 96817
$109,642

Mayor's Office for Senior
Citizens and Handicapped
"Social Services Project"
180 North LaSalle Street
Chicago, Illinois 60601
$136,800

TABLE XII. NEW MODEL PROJECTS FUNDED WITH FY 1978 FUNDS--Continued

University of Illinois
at Chicago Circle
"Data Base Development for
State Agencies"
Jane Addams College of Social Work
Post Office Box 4348
Chicago, Illinois 60680
$80,000

The University of Iowa
Multidisciplinary Gerontology
Center
"Community Care Project"
Oakdale Campus
Iowa City, Iowa 52242
$140,257

E. S. Edgerton Medical Research
Foundation
"Adult Restorative Services"
3400 Grand
Wichita, Kansas 67218
$107,717

North Kentucky Mental Health-
Mental Retardation Regional
Board, Inc.
"The MAC Senior Center"
430 Garrard Street
Covington, Kentucky 41011
$79,794

Murray State University
Department of Special Education
Division of Speech and Hearing
"Environmental Communication
Intervention for the Aging"
Murray, Kentucky 42071
$57,000

Cumberland-York Task Force
on Aging
Disaster Assistance
142 High Street, Suite 401
Portland, Maine 04101
$20,000

The Assistance Group for Human
Resources Development, Inc.
"Comprehensive Care System"
8555 Sixteenth Street, Suite 400
Silver Spring, Maryland 20901
$138,866

Assessment and Resource Center
Mental Health Programs, Inc.
"Geriatric Assessment and
Resource Center"
56 Fenwood Road
Boston, Massachusetts 02115
$174,330

Department of Elderly Affairs
Disaster Assistance
110 Tremont Street
Boston, Massachusetts 02108
$40,000

SOMA Clinic
"Elderly Resocialization Program"
140 Chestnut Street
Cambridge, Massachusetts 02139
$173,470

The University of Michigan
Institute of Gerontology
"Evaluation of Community-based
Support Groups"
520 East Liberty
Ann Arbor, Michigan 48109
$72,000

The University of Michigan
Institute of Gerontology
"Nursing Home Councils Project"
520 East Liberty
Ann Arbor, Michigan 48109
$81,954

The University of Michigan
Turner Clinic
"Peer Support System"
1000 Wall Street
Ann Arbor, Michigan 48109
$30,000

TABLE XII. NEW MODEL PROJECTS FUNDED WITH FY 1978 FUNDS--Continued

State Agency on Aging
State of Minnesota
Disaster Assistance
Metro Square Building
St. Paul, Minnesota 55101
$48,596

Nebraska Commission on Aging
Disaster Assistance
Post Office Box 95044
301 Centennial Hall, South
Lincoln, Nebraska 68509
$40,000

Inter-Tribal Council of
Nevada, Inc.
Department of Health and
Social Services
"A Model System for the Delivery
of 23 Rural Nevada Indian
Reservations"
650 South Rock Blvd., Building 11
Reno, Nevada 89502
$96,230

New York City Community College
of CUNY
Division of Continuing Education
"Educational Service to the
Elderly Homebound"
300 Jay Street
Brooklyn, New York 11201
$67,926

Jamaica Service Program for
Older Adults
"Consortium of Aging Services"
163-18 Jamaica Avenue
Jamaica, New York 11432
$157,260

Community Service Society of
New York
"Natural Supports Program"
105 East 22nd Street
New York, New York 10010
$150,000

New York City Housing Authority
Department for the Aging
"Senior Resident Advisor Program"
250 Broadway
New York, New York 10007
$139,547

American Jewish Committee
"Intergenerational Relations
Project"
165 East 56th Street
New York, New York 10022
$50,000

Monroe County Long-Term Care
Program, Inc.
"Extending Access"
Plymouth Park West
55 Troup Street
Rochester, New York 14608
$176,400

Ohio State School for the
Deaf Alumni
"Columbus Colony"
6971 Sunbury Road
Westerville, Ohio 43081
$250,000

State of Oregon
Department of Human Resources
"Flexible Intergovernmental
Grant Project"
315 Public Service Building
Salem, Oregon 97310
$150,000

Institute on Aging
"Community Education Providing
Care for the Elderly"
Portland State University
Post Office Box 751
Portland, Oregon 97207
$29,997

TABLE XII. NEW MODEL PROJECTS FUNDED WITH FY 1978 FUNDS--Continued

Cambria County Board of Commissioners
Cambria County Area Agency on Aging
Cambria County Courthouse
Disaster Assistance
Edensberg, Pennsylvania 15931
$91,404

State Office on Aging
"Long-Term Care Planning and Development"
Post Office Box 2675
Harrisburg, Pennsylvania 17120
$199,808

Jefferson County Area Agency on Aging
Jefferson County Service Center
"Health Education & Social Service/Primary Care Coordination Demonstration Project for a Rural Area"
Rural Delivery #1
Brookville, Pennsylvania 15825
$107,000

Department of Elderly Affairs
Disaster Assistance
150 Washington Street
Providence, Rhode Island 02903
$40,000

Senior Citizens Services, Inc.
"Deinstitutionalization Program"
3373 Poplar Avenue, Suite 401
Memphis, Tennessee 38111
$177,069

University of Wisconsin
"Community-Based Learning Centers for Older Adults"
Faye McBeath Institute on Aging
425 Henry Mall
Madison, Wisconsin 53706
$102,731

10. TECHNICAL ASSISTANCE

During fiscal year 1978, the Administration on Aging distributed seven technical assistance handbooks designed to guide State and area agencies in developing and strengthening the following priority services for older persons:

—Information and referral.
—Legal.
—Nursing home ombudsman.
—Homemaker and home health.
—Senior centers.
—Employment.
—Residential repair and renovation.

These handbooks include information on the importance of the service to older persons, service definitions, alternative service models, and the role of State and area agencies in service development. Handbooks for transportation and nutrition services were disseminated to the aging network before fiscal year 1978.

During fiscal year 1978, a number of technical assistance memorandums were also disseminated to the network, covering such subjects as:

—Investigation of possible linkage with State and local government ombudsman/complaint handling mechanisms.
—Civil rights responsibilities in aging programs.
—Wisconsin State policies on distribution, resoluton, and clearance of audit reports.
—Model budget reporting system.
—Guide for developing nutrition services in community health programs.

11. EVALUATION

During fiscal year 1978, AA continued work on two major longitudinal evaluation studies of the title III area planning and social services program, and the title VII nutrition program for the elderly. The first phase report of the title III evaluation was published in February. The first phase of the nutrition evaluation was published in January 1979. The second phase report of the title XX evaluation was also published. Descriptions of their major findings follow. In addition, a new evaluation study on the "Over Easy" television program was conducted in fiscal year 1978. It showed that many older people watched the program and reported interest in it. Finally, the evaluations of title IV–A career training and interagency agreements are continuing.

MAJOR FINDINGS AND POLICY IMPLICATIONS FROM PHASE I OF THE EVALUATION STUDY ON AREA PLANNING AND SOCIAL SERVICES

Many of the findings of the evaluation of the area planning and social services program may have significant implications for policy formulation, program regulations, and operating instructions. In this summary are listed several of the most noteworthy findings.

1. *Area agencies have contributed to positive changes in services to the elderly and have an important role to play.*—Even though area agencies had only been in existence for about 2 years at the time of the evaluation study it was apparent both from data and the perceptions of community leaders that area agencies have played an important role in bringing about changes in services for the elderly. Area agencies are effective change agents. While this study does not "prove" the absolute need for area agencies, it does show that they are having a definite impact in their communities.

2. *Area agencies were rated highly by others in community.*—The cooperation, coordination approach of the area agencies seems to produce a high level of effectiveness, as well as community acceptance and appreciation. This argues well for the continuation and furthering of the area agency type of approach to planning, coordination, pooling, and provision of gap-filling and supportive services, in addition to advocacy and funding.

3. *Area agency assistance in the provision of transportation services was linked to area agency effectiveness.*—Service providers most frequently mentioned transportation as the No. 1 service area needing improvement. It is clear that simply providing social services is not enough. It is often necessary to

"get the people to the service." Many of the elderly may not have access to private or public transportation. Although transportation has been one of four "national priority" services, it is still inadequate to meet the need, according to service providers.

4. More planning activities by area agencies are associated with more improvements in services to older persons, per service provider.—Service providers do not identify planning activities of the area agency as directly related to specific improvements in the delivery system. However, the findings show that usually the more time the area agency devoted to planning the more improvements were observed per service provider, up to a certain level of planning.

5. Area agencies are especially effective among service providers they fund.—The effectiveness of the area agency as a "change agent" is enhanced when they are able to help fund a service provider. Service providers are more responsive to area agencies who help them by providing funds.

6. Area agencies are effective using nonfunding methods as well.—When asked to state what they felt to be the area agency's greatest achievement, the responses given most often by the State units on aging, members of the area agency advisory councils, and knowledgeable influential community leaders not directly involved in service delivery to the elderly, pertained to the area agency's nonfunding activities. Improvements in the coordination of local services and increased public awareness of the needs of the elderly were two of the frequently stated major achievements.

Overall, the area planning and social services program, with its focus on planning and coordination, and its capacity for providing or gap-filling and supportive services (for example, transportation), has shown, in its first 2 years, an ability to face up to the needs of the elderly in America.

FINDINGS FROM PHASE I OF THE EVALUATION STUDY ON THE NUTRITION PROGRAM FOR THE ELDERLY

Data collection from the first-wave findings from phase I occurred between August 1976 and March 1977. This analysis describes program activities in the context of several issues of concern: enrollment of the priority elderly, the relationship of outside social activity to program participation, participant contributions, level of participation, area agency roles in the nutrition projects, service delivery characteristics, and use of program services. Also discussed are the characteristics of sample participants, along with baseline data on the participant impact measures. The report describes differences among recent entrants, long-term participants, former participants, and nonparticipating neighbors (cross-sectional analysis). The longitudinal analysis of impacts, of course, must await results of subsequent data collection waves.

ENROLLMENT OF PRIORITY ELDERLY

Nutrition projects are placing substantial emphasis on serving the low-income and minority elderly. Nearly two-thirds of the sampled participants have annual family incomes of less than $4,000 and one-fourth belong to an ethnic minority. However, the sample sites enroll few mobility-impaired and non-English-speaking elderly, who account for only 2 percent and 3 percent of the sample participants, respectively.

Enrollment of the low-income and minority elderly is greater at those sites which: (1) are located in areas with large concentrations of these special populations; (2) provide opportunities for recreation and social interaction; and (3) tend to have high participant attendance rates in general. These site characteristics appear to be more important than outreach methods in terms of attracting minority and low-income older persons.

LEVEL OF SOCIAL ACTIVITY AND PARTICIPATION IN PROGRAM

Persons who are most socially active, as measured by church and other organizational participation, are most likely than other elderly to participate in the program. Seventy-four percent (74 percent) of recent participants and 76 percent of long-term participants are classified as "socially active," as opposed to only 58 percent of nonparticipating neighbors.

PARTICIPANT CONTRIBUTIONS

With only one exception, all sample sites collect contributions from participants, but their policies and procedures for collecting these sums vary. At two-thirds of the sites a specific contribution amount is suggested, while at others participants are asked to give what they can. Typically, site-suggested sums are low, ranging from 25 cents to 88 cents. A total of four sites, however, suggest donations of $1 to $1.60.

In general, participants approve of the notion of contributing for meals and have not found it financially burdensome. Most feel they save money by participating in the program. Where donation amounts are suggested, participants registered overwhelming approval of the amount, and the policy appears to be flexible enough that participants can be served whether they donate or not.

Despite the positive attitudes and flexible policies, there is evidence from some sites that contributions are viewed as payments for meals by both staff and participants. A substantial minority (20 percent) of participants think they are charged for meals. At 14 percent of the sites this perception is shared by more than half the sampled recent entrants. These sites suggest a specific donation which participants pay directly and nonanonymously to a staff member or volunteer. At sites which collect donations anonymously, participants are more likely to view the sum they give as a voluntary contribution than a charge for the meal.

LEVEL OF PARTICIPATION

Participants reported a wide range of attendance patterns, varying from daily to less than once a month. However, the vast majority attend once a week or more. The most frequent attendees were found to be long-term participants and the priority elderly: The poor, ethnic minorities, and those living alone who eat meals away from home. Frequent attendees are also likely to be over 75 years of age and feel they are not in good health.

Site records revealed an average attendance rate of 2 to 3 days per month for all sample participants. However, among sites, attendance rates range from just over once a month to nearly 5 days a week. Site attendance rates were found to be higher at sites which: (1) emphasize recruitment of priority elderly; (2) suggest minimum contributions which can be given anonymously; (3) provide frequent recreation activities, religius observances, and informal social interaction opportunities; and (4) have a relatively long operation history.

Transportation problems may prevent many participants from attending as often as they would like. Difficulties in getting to mealsites were most often cited by participants at sites with low attendance rates. The most frequent attendees reported the fewest transportation problems.

Participants' views of meal services appear to have little effect on participation levels. Sites with high attendance rates may experience difficulty in finding ample space and meals for all attendees. These sites had significantly more participants who had attended when they could not be served due to lack of space or food. This experience, however, has not discouraged or detracted from the appeal of sites with high attendance levels.

AREA AGENCY INVOLVEMENT

Typically, area agencies on aging have either a structural or working relationship to the nutrition project. Area agencies are grantees for 20 sample projects. Of the area agencies which were not grantees, 29 have working relationship with the project, and another 24 area agencies have some type of authority over the projects. The remaining 18 projects did not have area agency relationships.

Area agencies had filled various roles in nutrition projects, particularly in planning, technical assistance, training, and management. Level of area agency involvement tended to be greatest among grantees and least among agencies with only a working relationship. Projects operating under area agency grants were found to offer a broader range of supportive services (with the exception of health services) than other projects.

MEAL SERVICES

The great majority of participants are satisfied with the meals. Where dissatisfaction exists it tends to be at sites which: (1) are relatively large, (2) spend smaller portions of their overall budgets on meal services than other sites, and (3) have comparatively more participants who reported attending meals when they could not be served. (Participants reporting this experience were a small minority but tended to be concentrated at 17 of the 91 sites. While there are insufficient data at present to determine the cause of this problem, it will be explored during the second wave of the study.)

Nutrition projects in the sample spend an average of $1.80 per meal, considering all meal-related expenditures. However, among projects, these costs range from 59 cents ot $2.73 per meal. Based on all project expenditures, costs per meal average $2.82, and range from $1.07 to $6.03 among sample projects. Costs tend to be higher among projects that are small, rural, Northeastern, Western, and located in apartment complexes. The cost per meal tends to be lower than average among large projects, urban projects, those in the Rim South, and those preparing their own meals. The intercorrelation of these variables makes it impossible to determine their relative influence on project costs without further study.

TRANSPORTATION SERVICES

Transportation services are provided by the vast majority of sites. Project transportation appears to be used primarily by participants who lack other options, including those who are over 75 years, the very poor, women, and those who live in rural areas. Meal sites which do not furnish transportation are typically located in urban apartment complexes or community center facilities and serve a relatively small clientele.

RECREATIONAL SERVICES AND SOCIAL INTERACTION

Participants who are black, female, and nonhandicapped become active in project functions more readily and report a higher level of social interaction than others. Sites which appear to be successful in meeting the social needs of new participants are those which: (1) are small, and seat participants at small tables to encourage interaction; (2) have some type of religious activity, such as a grace before meals or hymn singing, (3) offer informal recreation activities onsite rather than at other project locations, making these activities available on a frequent basis; and (4) are located in facilities which participants feel are pleasant places to go.

NUTRITION EDUCATION SERVICES

While most participants are not aware that nutrition education is provided, there is greater awareness of (and participation in) these activites among women, food stamp recepients, and those who are active in other aspects of the program. For the acitve participants attendance at this kind of activity may be primarily socially motivated, while food stamp recipients may be motivated to learn ways of getting the greatest nutritional value for the food dollar. There is greater participation in "innovative" nutrition education programs——those which minimize traditional pedagogic methods and use social and recreational techniques, enabling participants to take an active part in the program. Programs at smaller sites have the greatest participation and were judged most useful by respondents.

SHOPPING ASSISTANCE

Although a large majority of sites provide shopping assistance, few participants know of and utilize it. "Active" participants are more likely than others to be aware of this supportive service, but only the most needy are likely to use it—those on very low incomes, over 75, female, and food stamp recipients. Sites which provide shopping assistance frequently and regularly have greater participation than others.

HEALTH SERVICES

Projects do not appear to be making enough effort to apprise participants of health care benefits and services available to them. Participants who are knowledgeable about health services tend to be those persons who are socially active, and presumably obtain information at their own initiative.

IMPACT OF PROGRAM ON PARTICIPANTS

Differences between participating elderly and nonparticipating elderly were measured for seven variables. Program effect cannot be measured from the first year's findings. Measurement of program effects will come from data collected over time based on continuing interviews with panels of participating and nonparticipating elderly.

MEETING DIETARY NEEDS

Based on respondents' reports of their food intake within 24 hours prior to being interviewed, analysis indicates positive effects of the program on dietary intake, as measured by the amounts of specific nutrients consumed. In general, participants eat better than do nonparticipants. This difference is primarily on days when they eat at the site. As a result of eating at the site, calcium and vitamin A show the greatest differences in intake.

ISOLATION

Participants are more likely than nonparticipants to live alone, and to be members of religious and social groups. The combination of living alone and having an inclination toward social interaction suggests that the program attracts primarily those elderly who find themselves involuntarily isolated (e.g., through loss of family or spouse and lessened social mobility), rather than elderly who are voluntarily isolated (i.e., those persons who have probably never been inclined toward organized social activity).

LIFE SATISFACTION AND PSYCHOLOGICAL WELL-BEING

As measured by the Bradburn "affect balance" scale, participants tend to show more positive effect with increased length of participation in the program. On two measures of life satisfaction and mood, participants in general show slightly more favorable readings than do nonparticipants.

HEALTH (MOBILITY AND PERCEPTIONS OF HEALTH STATUS)

Both participants and nonparticipants show a high level of mobility, as measured by a number of indicators, including getting out of the house, personal care and care of the home, and use of health aids, such as canes. There are no differences between participants and nonparticipants in terms of self-perception of health. Almost half of all elderly interviewed report their health as good or excellent (as opposed to average, fair, or poor).

INSTITUTIONALIZATION AND LONGEVITY

Differential rates of institutionalization and longevity are longitudinal variables which will be assessed over time, using continuing panels of elderly participants and nonparticipants.

INCOME AND INCOME SUFFICIENCY

Participants report generally lower income levels than do their nonparticipating neighbors. However, those who participate tend to perceive their income as better meeting their needs than those who do not participate.

SUMMARY OF THE MAJOR FINDINGS OF EVALUATION OF IMPLEMENTATION OF TITLE XX

The 2-year study examined the nature, objectives, and results of State and area agency on aging intervention in title XX.

State and area agencies have been more active in social services decisionmaking than they were prior to title XX. Other individuals, agencies, and organizations, however, were more active as well.

The nature of State and area agency intervention consisted of the negotiation of cooperative agreements, participation in title XX advisory councils, exchange of plans and needs assessment materials, review and comment on CASP plans, attendance at public hearings, and negotiation of purchase of service agreements.

The objectives of these activities were primarily oriented toward securing a "fair share of title XX resources for the aging. Based on the fragmentary data available, it appears as though this goal has been accomplished.

Among the major lessons to be learned from the title XX experience are:

—State and area agency activity positively correlates with results.

—In States not at ceiling, the opportunity for State and area intervention remains.

—In States at ceiling, State and area agencies have a responsibility to prevent service cutbacks, and an opportunity to secure additional Federal, State, and local funds.

—State and area agencies on aging are increasingly pursued as funding sources by their title XX counterparts.

—Cooperative agreements are not self-implementing and should be regarded as the beginning of a coordinative process rather than the end.

—Nonmonetary concerns which may be even more imporant than the "fair share" issue include service mix, service outcomes, and program policy.

Administration on Aging Evaluation Projects

Completed in fiscal year 1978:	
Evaluation of implementation of title XX (second year)—cosponsored with SRS Public Services Administration	$75,000
Area planning and social services program evaluation (first year)	700,000
Evaluation of "Over Easy"	190,000
Ongoing projects:	
Evaluation of title IV–A career training program	144,493
Evaluation of use and effectiveness of interagency agreements at Federal, State, and local levels	240,000
Area planning and social services program evaluation (second year)	750,000
Longitudinal evaluation of the nutrition program (second year)	645,000

12. THE NATIONAL CLEARINGHOUSE ON AGING

The National Clearinghouse on Aging as mandated by title II of the Older Americans Act, is responsible for the collection, analysis, and dissemination of information about older people and their needs. The need for a comprehensive information system in the field of aging has been well documented. During fiscal year 1978, the Clearinghouse continued to expand its activities in the areas of public information, statistical analysis, public inquiries, publication distribution, and information referral policy.

SERVICE CENTER FOR AGING INFORMATION (SCAN)

SCAN is an automated bibliographic information system designed to facilitate utilization of the expanding knowledge base of gerontological literature and research findings. The SCAN model has been designed with attention to certain features which make it a functional and useful system for practitioners and service providers as well as researchers, teachers, and students. Fiscal year 1978 marked the initial implementation of the SCAN system[1] which is to be completed in phases. The SCAN system consists of three decentralized resource centers and a central control facility. Each center will be responsible for collecting, indexing, and abstracting reports and articles in their respective areas. Organization of the centers cover three major areas: Biomedical, behavioral/social sciences, and social practice. Each resource center and the central control facility will also prepare special publications for users which may include items such as:

—Current events newsletters;

—Papers by subject specialists addressing issues in both research and social practice areas;

—User guides and manuals.

PUBLIC INQUIRIES AND PUBLICATION DISTRIBUTION

During fiscal year 1978, public inquiries staff responded to 4,119 letters; 8,450 telephone requests for information and/or publications; 1,329 visitors were assisted; and 719,317 publications were distributed. Staff responded to inquiries about programs serving the elderly: Education and employment opportunities in the field, economic, housing, transportation, and medical problems of the elderly, and many other subjects that affect the older person. Inquiries were received from the White House, Congress, schools and universities, practitioners, national organizations, and elderly people themselves.

---

[1] Contract with Norman Hodges & Associates for SCAN central control facility.

Publications distributed by the Division were largely those published by the Administration on Aging. Notwithstanding, the Division also collects and disseminates publications produced by the Social Security Administration, National Institute on Aging, Census Bureau, Labor, HUD, Agriculture, and by many other Federal and national organizations on subjects of interest to older people.

Public inquiries staff have been increasing activities in case management. If the requests seem to warrant it, public inquiries staff talk to the constituents directly, querying them about their problems. Those requests for assistance that seem to be of an urgent nature are referred directly by staff to the area agency on aging for service.

Information and referral: During fiscal year 1978, the Clearinghouse information and referral policy staff provided leadership to the Interdepartmental Task Force on Information and Referral. The task force developed a guide which establishes baseline criteria for information and referral. AOA printed and distributed this guide to the 16 agencies participating in the task force as well as the aging network. AOA has also prepared a report of task force activity for fiscal year 1978.

Statistical analysis staff: In addition to providing technical assistance and demographic information to AOA and the network of State and area agencies on aging, the statistical analysis also produces a number of publications. Table XIII lists statistical analyses produced in fiscal year 1978 and scheduled for fiscal year 1979.

TABLE XIII. NATIONAL CLEARINGHOUSE ON AGING STATISTICAL ANALYSES

Statistical analyses produced in fiscal year 1978:

1. Statistical Reports on Older Americans No. 3—Some Prospects for the Future Elderly Population; January 1978.
2. Statistical Reports on Older Americans No. 4—Social, Economic, and Health Characteristics of Older American Indians (part 2 of 2).
3. The Elderly Population: Estimates by County, 1976.
4. Facts about Older Americans 1977 (brochure).
5. Statistical Notes 1. This series includes information on recently published statistical articles and reports.
6. Statistical Notes 2. (Same as 5.)

Statistical analyses scheduled for fiscal year 1979:

1. Statistical Reports on Older Americans—The Black Elderly.
2. Statistical Reports on Older Americans—The Rural Elderly.
3. Statistical Reports on Older Americans—Employment and Unemployment of the Elderly.
4. Statistical Reports on Older Americans—Characteristics of Homes Occupied by the Elderly.
5. Statistical Reports on Older Americans—Housing. Reprint from article to be issued by HUD.
6. Statistical Notes, 3, 4, 5, 6 (see No. 5 for fiscal year 1978).
7. Facts about Older Americans 1978 (brochure).
8. Inventory of Federal Statistical Programs.
9. The Elderly Population: Estimates by County, 1977.

13. OFFICE OF PUBLIC INFORMATION

As a result of a reorgaization completed during 1978, the public information functions were established in the Office of Public Information, reporting directly to the Commissioner on Aging. The Office of Public Information provided support for the National Network on Aging and many private agencies working for and with older persons. Emphasis was on increasing public awareness of the circumstances, needs, and contributions of the older population. OPI also initiated an agency speakers bureau which coordinated official speaking engagements by AOA executive staff members.

The Office of Public Information also expanded distribution of AOA's general audience film to high school and college audiences. "Don't Stop the Music," an 18-minute film which describes problems of aging and ways in which communities can help, was seen by over 124,000 viewers in fiscal year 1978, almost twice as many as the prior fiscal year. The film continues to be in heavy demand, as indicated by the 1,400 advance bookings at the end of fiscal year 1978.

For Older Americans Month, the Office of Public Information drafted a Presidential proclamation, produced media lists, and published an Older Americans Month poster. The poster was published to provide promotion, visibility and awareness of the needs of older Americans in "family, home, and community services"; 250,000 copies of it were distributed to State and area agencies on aging, nutrition sites, organizations in the field of aging, senior centers, libraries, and others interested in aging. Media kits were also distributed for the promotion of Older Americans Month. The kits contained news stories, radio scripts, proclamation suggestions for mayors, State Governors, et cetera; as well as background information for use in communities for promotion of events and services. More than 15,000 kits were distributed.

Aging magazine entered its 28th year of continuous publication. As the single most comprehensive source of information on Federal aging programs, it reports on innovative developments, proposed programs, legislation and studies in the field of gerontology. During 1978, focal issues of the magazine carried in-depth coverage of subject areas such as "Crime and the Elderly," "Future of Aging in America," "Senior Centers," "The Black Elderly," and "Death and Dying."

14. INTERAGENCY COOPERATION AND COORDINATION

A. INTERAGENCY AGREEMENTS

The Administration on Aging has negotiated and signed 23 working agreements with other Federal agencies, as shown in table XIV. The purpose of these interagency agreements is to mobilize, facilitate, and coordinate the use of existing Federal resources to meet the needs of older persons. These agreements are reinforced by agreements negotiated by counterpart State agencies. As of June 1, 1978, there were 320 State level interagency agreements in effect in support of Federal level agreements relating to the elderly.

TABLE XIV. WORKING AGREEMENTS

Adult services (Public Services Administration/HEW).
Affirmative action (Civil Service Commission).
Community action programs (Community Services Administration).
Community development (Department of Housing and Urban Development).
Crime and victimization (Law Enforcement Assistance Administration).
Disaster assistance (Federal Disaster Assistance Administration/HUD).
Educational services (Office of Education/HEW).
Energy Conservation/Home Winterization (Federal Energy Administration, Community Services Administration, Department of Agriculture, Department of Labor, Department of Housing and Urban Development, ACTION, Public Services Administration/HEW.
Extension service (Cooperative Extension Service/USDA).
Health service (Public Health Service/HEW).
Health planning and resources development (Bureau of Health Planning and Resources Development/PHS/HEW).
Housing and social services (Department of Housing and Urban Development).
Information and Referral:
    (a) Social Security Administration, Public Services Administration.
    (b) Federal Interagency Task Force on I & R.
Legal services (Legal Services Corporation).
Medicaid (Medical Services Administration/HEW).
Mental health (National Institute of Mental Health/ADAMHA/HEW).
Native Americans (Administration for Native Americans, Indian Health Service, Office of Indian Education, Public Services Administration/HEW, Department of Transportation).
Nutrition sites in public housing (Department of Housing and Urban Development).
Rehabilitation services (Rehabilitation Services Administration/HEW)
School bus program (Office of Education/HEW).
School lunch program (Office of Education/HEW).
Transportation (Department of Transportation).
Volunteer services (ACTION).

B. FEDERAL REGIONAL COUNCILS AND FEDERAL EXECUTIVE BOARDS

During the past year the Office of the President and the Intergovernmental Affairs Division of the Office of Management and Budget have been studying the Federal regional councils and Federal executive board roles and functions. The activities of the FRC's and FEB's in the field of aging have become somewhat varied as the result of this situation. Some of the active programs where regional offices on aging continued to exert leadership have continued. Others have become dormant.

C. DIRECT DEPOSIT PROGRAM

The Administration on Aging continued to work with the Department of the Treasury on the expansion of the program for direct deposit of social security, supplemental security income, railroad retirement, and Veterans Administration checks through the use of the network on aging to educate older persons. Technical assistance was provided by AOA staff, and support was secured from the National Association of State Units on Aging and the National Association of Area Agencies on Aging. Treasury staff provided information to area agency directors at their national conference and followup memorandums were jointly issued by the Commissioner on Aging and the Assistant Fiscal Assistant Secretary of Treasury. Treasury developed and furnished educational materials to the network agencies.

Early in calendar year 1979, the Fiscal Service of the Treasury Department reported that a total of 9,469,387 recipients are now receiving their payments by direct deposit, an increase of 2,604,004 since January 1978. In reporting this increase, it acknowledged that: "The efforts of the Administration on Aging certainly were instrumental in this growth of the direct deposit program."

FOOD AND DRUG ADMINISTRATION

Laws enforced by the Food and Drug Administration (FDA) are designed to protect the health, safety, and pocketbooks of all consumers regardless of age. But this protection is particularly important to the elderly consumer, who has interests and special problems peculiar to this age group. During 1978, there were many events and actions which illustrate the significance of FDA's protection of the elderly.

1978 ACCOMPLISHMENTS

CONSUMERS TRAINED TO INFLUENCE AGENCY POLICIES

FDA launched a "grassroots" project to educate consumers on how they can be more effective in influencing agency policies and regulations.

The project, known as the "national consumer awareness and access project," will train leaders of consumer organizations as well as representatives of minority and ethnic groups. The first training sessions, consisting of 3- and 6-hour courses on the agency's administrative procedures, were held in Boston, Chicago, New York, Pittsburgh, St. Louis, Denver, and Los Angeles.

This program is intended to increase the quality and quantity of citizen participation in FDA activities. FDA's goal is to help consumers influence more significantly the regulator decisions that affect their daily lives.

WARNING LABELS PROPOSED FOR HAIR DYES

In 1978, FDA proposed a warning label for many permanent type hair dyes. The warning labels are required on all hair dyes containing 4-methoxy-m-phenylenediamine (4MMPD) and its sulfate (4MMPD sulfate). These chemicals also are known as 2,4 diaminoanisole (2,4 DAA) and (2,4 diaminoanisole sulfate (2,4 DAA sulfate).

The FDA action was based on studies conducted by the National Cancer Institute which showed that 4MMPD sulfate causes cancerous skin, lymph and thyroid tumors when fed to laboratory mice and rats. FDA also had evidence that 4MMPD can be absorbed through human skin and enter the bloodstream.

Congressional repeal is being sought for a provision in the Food, Drug and Cosmetic Act which exempts coal tar-derived hair dyes from the adulteration section providing the label alerts consumers to the risks of skin irritation.

DRUG REGULATION REFORM ACT OF 1978 ANNOUNCED

The Drug Regulation Reform Act of 1978 was introduced into Congress in March 1978. The bill proposes a total overhaul of the system by which the Government regulates the development and marketing of drugs.

It is the first complete restructuring of the drug laws in 40 years, and is a major reform that implements President Carter's commitment to reduce the burden of unnecesary regulation and to make Government more open and more responsive to the needs of our citizens.

The bill has eight main purposes:

(1) Increase consumer protection by including all drugs within the same system of regulation, by confirming FDA authority to require postapproval surveillance of drug use, by giving FDA authority to require postapproval scientific studies, and by making it easier to remove an unsafe drug from the market.

(2) Increase consumer information and protect patient rights by confirming FDA authority to require plain-language patient package inserts on Rx drugs, by providing authority for FDA to require informed patient consent to the use of high-risk drugs, and by defining "safety" to mean that benefits clearly outweigh risks.

(3) Encourage drug innovation by simplifying regulations through the reduction of regulation during the early phase of drug research, and by providing for ground rules and informal procedures to help FDA and drug sponsors communicate more effectively.

(4) Make additional drugs available by providing a "fast track" for "breakthrough" drugs, by allowing a restricted distribution system for valuable drugs that otherwise could not be approved, and by allowing the export of unapproved drugs under certain conditions.

(5) Promote competition and cost savings through generic drugs by making it easier for a sponsor to obtain approval of a generic drug, by mandating a drug compendium, by requiring that pharmacies post drug prices, and by prohibiting unethical drug promotions including gifts, gimmicks, drug samples, and "reminder" ads, by requiring detailmen to leave full labeling with M.D.'s, and by regulating surveys of prescription files and by corrective advertising.

(6) Increase FDA openness and public accountability by releasing to the public the safety and effectiveness data which provide the scientific basis for FDA drug approvals, and by including the public in drug decisions through public hearings, advisory committees, and payment of attorney fees for citizen representation.

(7) Improve FDA enforcement by expanded inspectional authorities, subpena power, civil penalties, administrative disqualification, and by exempting physicians from criminal penalties.

(8) Encourage research and training by establishing in HEW a National Center for Clinical Pharmacology.

FDA, NEW YORK STATE SIGN DRUG AGREEMENT

During 1978, the Food and Drug Administration and the State of New York signed an agreement designed to encourage greater use of generic drugs and thus cut the costs of medicines bought by the State for use in its hospitals and outpatient medical facilities.

Under the agreement, each time New York State is awarding a contract to buy drugs, it will ask FDA to give specific assurances that the low bidder meets all FDA standards (for example, does the firm's processing plant comply with all FDA regulations, have there been recent recalls or manufacturing problems, and so forth). In each case, FDA will review its inspection records and, if necessary, inspect the low bidding firm before advising New York.

The aim of the agreement is to permit all drug companies meeting FDA quality standards to compete on an equal basis for the State's business. The assurance from FDA will give State contracting officials the extra confidence they need to buy drugs from the lowest qualified bidder. FDA now provides similar quality assurance to drug buyers in the Defense Department, Veterans' Administration, and other Federal agencies.

The program with New York is the first of its type between a State and FDA. If it proves successful in reducing drug costs to New York, FDA expects to be asked for similar assistance by other States.

In an earlier effort to lower drug costs through greater marketing of generic drugs, FDA helped New York prepare a list of dugs that are approved by FDA and which identifies all chemically identical drugs considered by the agency to be therapeutically equivalent.

LABELING OF "PAID" BLOOD DONORS BEGUN

In 1978, FDA required all whole blood intended for transfusion to be labeled as coming from either a "paid" or "volunteer" donor.

Blood from paid donors and commercial blood banks has been shown to be 3 to 10 times more likely to cause hepatitis than blood from volunteer donors. Hepatitis is a serious liver infection which is estimated to occur in about 200,000 persons annually from infected blood following transfusions, which is now mostly non-A, non-B hepatitis.

The labeling regulation was designed to reduce the risk of transmitting hepatitis through blood transfusions.

NEW BLOOD PRESERVATIVES APPROVED

FDA approved a new blood preservative that extends by up to 67 percent the shelf life of human blood for transfusion.

The product is called citrate phosphate dextrose adenine (CPD-adenine). It allows whole blood and red blood cells to be stored for up to 35 days before being used for transfusions. Blood preserved with present solutions can be stored for only 21 days. Preservatives are necessary to prevent whole blood from clotting and to keep red blood cells alive.

ULTRASOUND THERAPY STANDARDS ISSUED

FDA issued a mandatory safety performance standard to protect people from exposure to incorrect levels of radiation emitted by ultrasonic equipment used in physical therapy.

Ultrasound, a form of energy similar to but higher in frequency than ordinary sound waves, can penetrate body tissues. It is widely used by physicians and physical therapists to produce "deep heating" effects for relief of pain and to promote healing in muscles and joints.

The regulation is the first Federal mandatory safety performance standard for equipment that produces ultrasonic radiation. About 37.5 million ultrasound treatments are administered each year in the United States. About 15,000 ultrasonic therapy units are in use in hospitals and another 35,000 units are located in other facilities such as physicians' offices and nursing homes. Nine manufacturers of ultrasonic equipment supply a market of $8.5 million annually.

The new standard was issued because of FDA surveys which showed wide discrepancies between claims made for ultrasonic equipment and actual performance. The agency found, for example, that many units either delivered too little energy for effective treatment, or too much energy which can cause burns, swelling, and damage to nerve and other sensitive tissues. The standard will assure accurate delivery of ultrasound waves as claimed for the product and indicated by the equipment's controls. The standard also requires instructions and precautions to assure safe and effective use of equipment.

RECOMMENDATION PROPOSED FOR X-RAY QUALITY ASSURANCE PROGRAMS

In April, FDA issued a proposed recommendation for quality assurance programs in diagnostic radiology facilities.

Such quality assurance programs are expected to significantly reduce unproductive patient exposure to X-rays while maintaining or improving X-ray image quality. In addition, the agency has estimated that such programs could save hospitals up to $150 million annually, above the cost of the programs.

PROJECTED 1979 ACCOMPLISHMENTS

The Food and Drug Administration (FDA), United States Department of Agriculture (USDA) and Federal Trade Commission (FTC) have launched a major effort to learn directly from consumers what information they want on food labels.

The agencies invited consumers to express their views personally at five hearings across the country. Those who were unable to attend the meetings were invited to write.

Among the issues discussed were:

—Should ingredient labeling be required for all foods? (Some foods are excluded by law from ingredient declaration.)

—Should food labels tell the percentage of each ingredient in the product?

—Should raw commodities, as well as all processed foods, be required by law to carry full nutrition labels? (Now, only foods to which nutrients are added or which make a nutritional claim must carry the nutrition label.)

—Should all foods have "open dating"—such as the date on which a food was packed or the last recommended day of retail sale—and which date would be most useful?

—If a food is an "imitation" of another, should that food be called "imitation" or should it be given a new name?

—Are there types of foods to which vitamins and minerals should not be added?

—What current information on food labels is most important? Least important? What new information should be on labels?

In 1979 the consumer comments will be used to develop a coordinated strategy to improve food labels. The strategy may involve changes in current labeling regulations, the development of new regulations, or recommendations for new legislation. The goal is to make sure that the information on food labels is what consumers want and is presented in a way consumers can understand.

HEALTH CARE FINANCING ADMINISTRATION

Long-Term Care Studies and Demonstrations

On March 8, 1977, Secretary Califano announced a major reorganization of the Department of Health, Education, and Welfare. For the first time the medicare, medicaid, and quality assurance activities of the Department were consolidated into one organization, the Health Care Financing Administration (HCFA).

The consolidation of previously separate medicare, medicaid, and quality assurance activities greatly assists coordination and resolution of major issues relating to the Department's long-term care policies. Another purpose of the reorganization was to assist internal efficiency and economy and to encourage prudent financial management as well as to strengthen the ability to control fraud and abuse in the medicaid and medicare programs. The Secretary has recognized the major involvement of HCFA in long-term care programs by designating HCFA as the "focal point" within the Department charged with "responsibility for insuring coordination in the development of the Department's long-term care policies."

Health Care Financing Administration programs are the principal source of funding for long-term care services in the United States, funding skilled nursing, intermediate care facility, and home health care services. Moreover, HCFA conducts a program of research, demonstrations and evaluation in long-term care, particularly as it relates to the populations and services covered by medicare and medicaid. The Office of Policy, Planning, and Research, HCFA, is responsible for these activities.

The major objectives of these HCFA long-term care research, demonstration, and evaluation activities are to: (1) Address issues in major long-term care systems reform, including organization and delivery of long-term care services; provision of service packages benefit changes, financing, and reimbursement and quality and utilization control; and (2) develop data and analyses based on long-term care providers and clients, focusing on industry data on economics behavior, demand, and utilization of long-term care services, study of State and local initiatives, comparative analyses, and client characteristics.

DEMONSTRATION ACTIVITIES

In 1978, HCFA's first full year of operation of its demonstration and evaluation program, a number of new projects were approved, and some ongoing projects, originated in the Social Security Administration and the Social and Rehabilitation Services, were continued.

1. Comprehensive Planning and Development

A consortium of universities led by the University of Chicago received a grant to develop a coordinated approach to the design and development of long-term care projects. This approach involves the collaboration of a core group of knowledgeable planners, researchers, and State and local government representatives around the country to design, develop, and implement demonstration projects in five States. These demonstration projects will incorporate planned variations of the elements of financing, organization and delivery, and administration of long-term care services. The projects will be guided by a common policy and planning framework and set of objectives, a common research strategy with uniform data collection, and a consistent evaluation plan. The overall research objective of this coordinated approach to demonstration planning is to permit careful analysis of systemwide implications, to present alternative models for services and delivery, and to improve understanding of State and local development of long-term care services.

2. Community Long-Term Care Organizations and Services

Continuations were granted to Wisconsin to develop its community care organization for the elderly and disabled; to New York State to develop the Monroe County long-term care project; to Georgia to demonstrate alternatives to institutional care for nursing home patients through adult supportive living services, home delivered services, and adult day rehabilitation; and to Colorado to conclude its community care organization. A comprehensive long-term care program for the aged and disabled in Washington State concluded after its 3 years of operation.

The major common purposes of these projects are to attempt to provide a more rational assessment of long-term care needs, and redirect and reallocate services from an institutional orientation to greater reliance on community-based care for the chronically ill and disabled.

New projects funded in fiscal year 1978 consist largely of planning and development of specific community-based projects:

—In Minnesota, the Health Central Institute will develop a coordinated systems model for a rural area utilizing all existing health and social service resources as well as the medical care network. The focal points for services will be a hospital and nursing home, and a healthy seniors' center.

—Mt. Zion Hospital in San Francisco will develop an expanded, comprehensive service model for the aged which will include hospital care, day health care, home care, and other services; a unique aspect is the hospital-based nature of this program.

—On Lok Senior Health Services in San Francisco's Chinatown will develop a service along the lines of an HMO with prospective capitation budgets for a group of disabled elderly. Comprehensive services ranging from home-delivered meals and home care to institutional services.

—Granting of waivers and an evaluation of New York State's recently enacted long-term home health care program will test the feasibility of providing home-based care to medicaid clients judged to be eligible for institutional care. Unique features will be the breadth of services available and the placing of a cap on program expenditures on behalf of clients; the cap is pegged at a maximum of 75 percent of the nursing home rate in the locale.

—The Monroe County long-term care program, mentioned earlier, was authorized to expand its assessment and monitoring activities to include medicare clients, subsequent service coverage may be expanded through the granting of medicare waivers.

3. Benefit Expansions

A number of demonstration projects have been conducted to analyze the cost and quality consequences of "swing bed" policies wherein rural hospitals would be granted the flexibility to use excess hospital beds on a temporary basis to care for nursing home patients. The goal is to use different reimbursement rates for SNF patients in hospital beds, thus reducing acute care costs. At the same time, excess hospital beds and a shortage of nursing home beds would be alleviated.

Experiments are underway in two States to test the effects of removing the medicare requirement that patients be hospitalized for at least 3 days prior to admission to a skilled nursing facility.

INDIVIDUAL PROJECT SUMMARIES—ONGOING

1. The Communitywide Coordinating Systems

a. Wisconsin

The long-term objectives are: (a) To demonstrate that a substantial segment of the elderly and functionally disabled population may be maintained in their own homes or in community settings at a cost lower than that of the present pattern of institutionalization through the provision of a packaged continuum of health and health-related social services; and (b) to demonstrate that the quality of care can be improved over that which is the experience of the medical assistance program.

The operation is basically the establishment of an administrative structure, called the "community care organization" (in cooperation with the State medicaid program and the particular county department of social services), which (a) Identifies indigent disabled persons appropriate for care within the community, (b) certifies their eligibility for medicaid financed health-related services, and (c) provides services. The community care organization (CCO) assumes responsibility for providing health-related services itself or subcontracting with other community agencies for specific services and arranges for required professional medical services in its role of coordinator. Thus, the CCO is a central contractor, funder, and coordinator of services to CCO clients. For a price negotiated in advance, it assumes responsibility for maintaining disabled persons in their homes or in the community at an appropriate level of quality care.

The first CCO was established at La Crosse, Wis., and is an urban/rural mix site. It has four contracts for day services: (a) For the multiple handicapped (St. Francis Hospital); (b) for older people (St. Francis Home); (c) for the mobile mentally handicapped; (d) for the older adults who are socially, physically, and/or mentally impaired (adult day care, Park Terrace Nursing Center). The CCO provides a vast array of health, therapeutic, nutritional, nursing, personal care, and home maintenance services designed for individual patients to meet the individual needs. Two additional sites have been developed: Milwaukee County CCO (urban site) and Barron County (rural site).

b. Washington

The research objectives are:

(A) To assess and interpret the impact of a coordinated system of community-based and institutional services which emphasizes the avoidance of inappropriate and unnecessary institutionalization through the use of two experimental sites and one control site.

Specifically:

(1) To assess the changes in patterns of service utilization in the project site for both community-based and institutional services.

(2) To compare the capacity of agencies and provides to render competent and appropriate service in the three project sites.

(3) To compare the impact of the program on the costs of meeting the supportive service and long-term care needs, both institutional and community-based, of disabled persons in the three project sites.

(4) To determine the characteristics and numbers of functionally disabled clients served by the community and institutional-based network in the demonstration sites.

The client population includes all individuals 18 and over who are (a) Function-Counties and Cowlitz-Wahkiakum Counties. Total caseload was 808, of which 503 were nursing home patients. In May 1977, the total caseload was 940, of which 543 were nursing home residents. The ratio of nursing home residents to total cases showed a strong decline especially in the Benton-Franklin Counties area. The ratio would be greater if additional services were available in the Cowlitz-Wahkiakum area; for example, adult day care, mental health services, protective services. Efforts are being made by project staff to assist in the development of these services during the third year.

The client population includes all individuals 18 and over who are (a) functionally disabled, (b) eligible for title XIX and/or title XX services, and (c) at risk of nursing home placement. The "at-risk" factor is further defined as individuals (a) Being discharged from hospital or other acute facilities who would be placed in a long-term care facility; (b) residing in the community who are unable to manage the tasks of daily living because of physical disabilities; and (c) residing in the nursing homes and not in need of that level of care.

The list of medical and health-related supportive services which are available according to the assessed levels of need is extensive, from in-home to institutional care. On August 1, 1977, "in home care services" were introduced to replace chore services.

During the third year, movement will be made toward preparing for statewide implementation of the project's successful components and providing input for possible changes in the State's medicaid plan.

There is strong support for the project in the legislative and executive branches of State government. On June 30, 1977, the Governor signed SSHB 251, an act which continues the services and funding initiated by HB 1316, the Senior Citizens Services Act of the previous legislation. It provides $11,820,000 to develop and expand alternative services and forms of care for senior citizens. The State has indicated interest in, and willingness to extend, this form of health and social services delivery statewide should be demonstration prove feasible and cost effective.

c. Georgia

The Department of Medical Assistance for the State of Georgia is attempting to demonstrate that the use of three major alternatives to nursing home institutionalization for medicaid within the State of Georgia would make possible the provision of more efficient and effective medical care to persons for whom such services are both appropriate and conducive to more independent living. The alternative services being tested are: (1) Adult supportive living services (adult foster homes, board and care homes); (2) home-delivered services (health and related services to beneficiaries in own or foster homes); and (3) special medical services (medical and health care related services for beneficiaries at a central facility on a day care basis).

Should the project succeed, the State would seek legislative and administrative changes through which these programs could be continued on a statewide basis.

The project looks at the recipient of alternative services within the experimental areas as an experimental group and the nonrecipients of alternative services (i.e. recipients of institutional nursing home care) as the control group. The three hypotheses to be tested deal with cost measures and serve to demonstrate that less expensive alternatives to nursing home care are possible and can be implemented. The average cost data for the new services will be compared with average nursing home cost data within the experimental districts.

The project also seeks to demonstrate the effectiveness of the experimental project in increasing the recipient's capacity for independent functioning. Effectiveness will be measured in two ways: (1) an evaluation of the health, mobility and activity levels of the patients; and (2) the patient's degree of satisfaction with the services he received. Assessment and comparisons of quality of care and patients' attitudes will be made.

d. New York

The New York project is a unique attempt to divorce long-term care services delivery within a community from barriers which are seen as inhibiting the development of coordinated health and social service programs which focus on preventing premature institutionalization. At the same time, it is an experiment with community response to the options of community decisionmaking concerning the forms of, and financing for, long-term care.

This demonstration will study procedures, community organization, service delivery, premium and payment control systems, and policy for community-controlled long-term care. Planning for the demonstration will consider the entire population at risk in the county as defined by the communitywide organization and in conjunction with a patient assessment center. Contracts will be arranged with State and local organizations, and the State Department and its affiliated local agency will monitor the community organizaiton's activities.

The major thrusts of the evaluation will be to (1) determine differences in cost-quality and overall satisfaction between the existing and the new systems to be modeled and demonstrated, and (2) evaluate the ease and relative importance of achieving different organizational arrangements for accomplishing the primary objectives.

e. Colorado

The objectives are: (1) to develop a communitywide, coordinated, and integrated system for the organization, delivery, and financing of health care and related support services for the medicaid-eligible elderly and adult disabled in their own homes or in the community, utilizing existing and new public and private health and social services resources, including institutional services; and (2) to demonstrate that these alternatives to the present fragmented "nonsystem" of out-of-institution delivery of health care and/or institutionalization (a) will be more cost-effective, (b) will reduce substantially the number of inappropriate placements in institutions, and (c) will improve quality of life through independent living with applied personalized medical and supportive services.

This demonstration will study the structure and processes of the Boulder County service delivery system before and after the demonstration at the first CCO site; community organization, participation and control; and service premiums and cost. Planning for the demonstration will consider the elderly and adult disabled Medicaid population at risk in the demonstration county as identified by the CCO staff although outreach, nursing home patient review, hospital discharge planning and referrals from other agencies, in conjunction with the interdisciplinary team at a patient assessment center.

Contracts will be arranged with State and local organizations. The department of social services, assisted by an advisory group (composed of representatives from the department's various units and from other departments of the State) will monitor the demonstration activities.

2. Utah—Payments Systems

The objective is to develop a cost-related payment system for long-term care patients and to determine its effectiveness on a statewide basis. System should be transferable to other States. The statewide experiment will enable a comprehensive test of the concepts, procedures, cost, controls, and quality of care contained in the cost-related payment system.

The project will develop two distinct profiles: A facility cost profile and a patient care profile. Data from these two profiles will be used to determine the payment an individual nursing home should receive. A point compliance system is being developed to monitor services provided by long-term care facilities. The compliance monitoring system is in the developmental stages and is subject to negotiation with providers within the State.

An evaluation of the project, its structure, processes, results, and effects on quality of care will be conducted by an independent contractor. This evaluation will include the feasibility of duplicating the project elsewhere as well as assessing the social and economic effects of the project.

3. "Swing-Bed" Projects

a. Utah cost improvement project (UCIP)

In January 1973, a 3-year contract was signed with the Utah Department of Social Services, Utah State Division of Health, to administer UCIP. The contract was subsequently extended twice and is scheduled to terminate on March 31, 1979. Originally, only 16 hospitals were approved for participation. Currently, 25 hospitals are participating. Generally, these hospitals have fewer than 100 acute beds, experience a chronic low occupancy rate of 60 percent, and are located in areas where long-term care beds are unavailable or inaccessible.

The rate of reimbursement for long-term care patients is the rate which each third-party payer (medicare, medicaid, private insurers) pays for the particular level of long-term care provided to the patient. For the medicare program, which only pays for SNF care, the rate is equal to the Utah title XIX SNF rate which was $25 per day in 1977. The medicaid rates for SNF, intermediate, and custodial levels of care are $25, $20, and $15, respectively. As with all "swing-bed" sites, the rates, which vary from site to site, only apply to routine services. Ancillary services are determined by whichever method of cost determination the hospital uses at the time of final settlement (either the ratio of charges or the combination method). Hospitals are eligible for an incentive payment from the medicare program but not from the medicaid program.

A contract was signed in March 1974 with the University of Colorado to evaluate UCIP. The final summary report was published late in 1978. The evaluation focuses on financing, utilization, and patterns of care, organizations, and the hospital's capacity to provide long-term care in addition to acute care.

The patterns-of-care area focuses on the effect of the UCIP on patterns of acute and long-term care in communities serviced by the program. Preliminary results from the first 2 years of the demonstration indicate that rates of use of long-term care in communities serviced by UCIP hospitals have increased with little or no change in patterns of acute care. Distances traveled to obtain long-term care have decreased during the demonstration.

The administrative evaluation area deals with such issues as attitudes of participants, implementation problems, and quality of care. A study of the availability of long-term care services and nursing resources in UCIP hospitals, as compared with Utah SNF's generally support these conclusions: (1) The diagnostic case-mix for UCIP patients is roughly the same as for patients from rural areas of Utah SNF's. Thus, physicians appear to admit the same kind of patients to both groups of providers. There is no evidence from this study that physicians sent patients with different types of diagnoses to UCIP hospitals. (2) Nursing time studies in 6 of the 25 UCIP hospitals showed that slightly more nursing time (for all categories of nurses: RN, LPN, and aide) was available to long-term patients in UCIP hospitals than in Utah SNF's. (3) Most nurses in UCIP hospitals supported the idea of providing long-term care in their hospitals.

b. Reducing acute care costs (RACC)

Based on this initial data from UCIP, it was decided to replicate the Utah experiment. As a result of a competitive solicitation, 3-year contracts were signed in July 1975 with the Texas Hospital Association and Blue Cross of western Iowa-South Dakota to administer the RACC "swing-bed" experiments. Hospitals began admitting long-term care patients in July 1976. The experimental phase will terminate on June 30, 1978, and the contracts will expire on March 31, 1979.

Approximately 40 hospitals participate in Texas and 20 in western Iowa-South Dakota. All of the hospitals satisfy the following conditions: (1) location in a rural area where long-term care is inaccessible or unavailable; (2) low acute patient occupany rates, averaging less than 80 percent; (3) less than 100 acute beds; (4) staff/patient ratio not exceeding two standard deviations of the average of all hospitals in the State of the same bed size; and (5) total full-time equivalents (FTE's) not exceeding the FTE average for the hospital for the preceding 5 years by more than 20 percent.

Medicare reimbursement for SNF routine services is at a fixed rate, per patient, negotiated between HCFA and the individual contractor. The negotiated medicare rate does not exceed the medicaid rate for the highest level of long-term care recognized by each respective State's title XIX program. The Texas SNF rate was originally $20.50, and was later adjusted upward to $23.37. The western Iowa hospitals receive $33.78 and the South Dakota hospitals, $17. All participating hospitals are eligible to receive financial incentives from the medicare program, defined as 50 percent of the difference between the medicare long-term care routine rate reimbursement and the incremental cost of providing long-term care. The Texas medicaid program began participation for SNF level of care in January 1978. The medicaid program in South Dakota makes payment for SNF, intermediate, and custodial level of care. Although the Iowa medicaid program is not participating in RACC, it makes the coinsurance payment for those beneficiaries who are medicare and medicaid eligible.

The evaluation of both RTCC experiments is being performed by the University of Colorado under a 3-year contract. The final RACC evaluation report is due to be published early in 1980. The evaluation will follow the general scheme of the UCIP evaluation; however, more emphasis will be placed on an examination of the quality of skilled care in participating hospitals.

c. Blue Cross of Iowa

In November 1975, Blue Cross of Iowa (BCI) submitted an unsolicited proposal to conduct a "swing-bed" experiment. An 11-month contract was signed in February 1977 and was subsequently extended so that the experiment will terminate on March 31, 1979.

Twenty-four hospitals are participating in this project and began admitting long-term patients in April 1977. The medicare SNF routine service rate is $40.

A major distinguishing feature of this experiment is that the hospitals are not eligible for an incentive payment, as permitted to Utah, Texas, and western Iowa-South Dakota. Therefore, a direct comparison of western Iowa-South Dakota and BCI results will permit a determination of whether an incentive is necessary to obtain the cooperation of small rural hospitals in providing SNF level services in their institutions, or whether it is sufficient to permit hospitals to use "swing-beds" to provide long-term care.

Another unique feature of the BCI experiment is that a penalty will be imposed when a hospital exceeds its previous highest level of full-time equivalent personnel. Unless additional personnel were previously approved by HCFA, the cost of these additional employees cannot be included in the routine costs of the hospital. The penalty will provide a direct control over the increase in personnel costs.

The University of Colorado will conduct an evaluation of the BCI experiment as part of its RACC evaluation.

4. Waiver of 3-Day Prior Hospitalization Stay Requirement

The 3-day prior hospitalization requirement is intended to limit the payment of SNF benefits to persons for whom such care may reasonably be presumed to be required in connection with continuous treatment following inpatient care, to lessen the likelihood of unduly long hospital stays and to assure that medical conditions and needs of medicare patients admitted to SNF's have been adequately medically appraised prior to admission. Many believe, however, that the 3-day prior hospitalization stay requirement has resulted in unnecessary hospital stays for medicare beneficiaries preceding transfer to SNF's. The Senate Finance Committee recommended that the Secretary conduct experiments to determine the effects of eliminating or reducing the requirement.

In response to a competitive solicitation, HCFA contracted with Blue Cross of Oregon and Blue Cross of Massachusetts, respectively, to administer experiments with the waiver of the 3-day prior hospitalization requirement. The contracts provide for a development phase, a 24-month experimental phase, and a 6-month final phase. Both Blue Cross of Massachusetts and Blue Cross of Oregon initiated the experimental phase in the SNF's in 1977.

By waiving the requirement at the participtaing SNF's, extended care coverage will be provided under several types of conditions, such as: Followup extended care services after receiving initial treatment or care in a hospital outpatient department, emergency room or hospital clinic; direct admission to an SNF after examination and certification by a physician of the need for extended care services; and, followup extended care services after a hospital stay of less than 3 days.

INDIVIDUAL PROJECT SUMMARIES—NEW

1. Wisconsin Nursing Home Quality Assurance Project

The Wisconsin Department of Health and Social Services will test the experimental survey procedures developed by the Wisconsin medicaid management study team. The surveys of nursing homes will be done by the teams who have been doing the "traditional" surveys but they will use the "new" survey instrument after the team have been instructed in its use. It is believed that the experimental system of surveying nursing homes will result in a more efficient and effective system of surveying, will result in an improvement of quality of care, and be less costly. The experimental method builds on the strengths of the old survey process and will provide two surveyors with the options to look quickly at the nursing home care delivery system using key quality criteria and to focus time and resources on problem areas. New method surveys, with consultation, can occur as often as necessary during the year rather than the "old" method of anual surveys.

2. A Coordinated Approach to the Design and Development of Long-Term-Care-Demonstration Projects

This proposal presents a coordinated strategy for the planning and design of long-term-care-demonstration projects. The basic approach involves the collaboration of a core group of knowledgeable planners, researchers, and State and local government representatives around the country on the design and development of demonstration projects in five States (Massachusetts, Illinois, Rhode Island, Minnesota, and California are tentatively designated). These demonstration projects will incorporate planned variations of the elements of financing, organization and delivery, and administration of long-term-care services. The projects will be guided by a common policy and planning framework and set of objectives, a common research strategy with uniform data collection, and a consistent evaluation plan. The overall research objective of this coordinated approach to demonstration planning is to enable careful analysis of the systemwide implications, to present alternative models for long-term-care services, and to better understand the process through which States and localities can develop comprehensive LTC service systems.

This proposal was developed jointly by individuals from several universities and with the cooperation of several State governments: The University of Chicago Center for the Study of Welfare Policy, the University of Minnesota Center for Health Services Research, the University Health Policy Consortium (consisting of Brandeis, Boston University, and MIT), and the health policy program of the University of California, San Francisco.

The specific objectives identified for the projects are: (a) Organize a full range of services which can be brought together on behalf of an individual client and adapted to the specific service requirements of the client, (b) tailor services to individual situations in a way that is judged to be most cost effective, (c) test and document the effects of alternative financing mechanisms for long-term care, including a capitation model, (d) implement a uniform cost accounting procedure for providers of care in order to measure and compare costs of alternative delivery systems and service combinations, (e) implement methods for assuring quality in long-term-care services, (f) test varying methods for assessing need for care and for matching service intervention with the assessed need, and (g) finance and organize service delivery in a way which recognizes the role of informal support arrangements.

3. Healthy Seniors Center—A Rural Model for Coordinated Service Delivery

This grant provides funds to plan and develop a model for coordinated and comprehensive services delivery within the total continuum of care for the elderly in a rural tricounty area in Winstead, Minn. A second application will be prepared in fiscal year 1979 requesting operational funds and titles XVIII and XIX waivers. The overall purpose of the project is to plan, develop, operate, and evaluate a rural community-based system of health services that assists older persons achieve an optimal level of health and self-sufficiency by offering a comprehensive and coordinated system of health services that is accessible, affordable, understandable and sensitive to changing personal needs.

During the planning and development phase, the applicant will define the health-related programs and service needs of the elderly population in the service area; determine which programs and services can be most effectively delivered on the campus of St. Mary's Hospital and Home (through the hospital, nursing home, proposed congregate housing project or the healthy seniors center itself); determine which programs and services for the elderly population can most effectively be delivered through off-campus community outreach into older persons' homes, apartments, et cetera; develop a "coordinated systems model" linking the services of the seniors health center with existing area resources, which assures older persons maximum access to both the on-campus and programs and services of St. Mary's existing community outreach services; and develop a healthy seniors services evaluation program (HSSEP) for implementation during the operational phase of the project.

The evaluation program will address the following issues: (a) Existing obstacles older persons face with attempting to gain access to health-related programs and services; (b) alternative strategies to overcome the organizational and financial obstacles to these health-related programs and services; (c) the need for future waivers of titles XVIII and XIX and county welfare programs to assure appropriate service delivery to older persons; and (d) analysis of operational data to be collected through a data collection system to assess the degree to which the healthy seniors center model achieves its stated objectives during its demonstration period and subsequent years of operation.

4. Long-Term-Care-Demonstration Design and Development

Mount Zion Hospital and Medical Center will plan and develop a comprehensive long-term health and social service delivery system for the frail elderly, which will demonstrate the capacity to give care in an appropriate, efficient, and cost effective system. Eleven specific objectives are identified and these include designing the services to be offered, developing a centralized intake process based on use of an assessment instrument, developing a central administrative system to deliver services, and developing a sound financial support plan.

Currently, Mount Zion has available a number of components which they will integrate into the new proposed comprehensive delivery system. These components are: (a) acute care, (b) emergency health services, (c) outpatient care, (d) home care, (e) medically oriented day care program, (f) information, counseling, and referral service for elderly patients, their families, and physicians, (g) transportation (vans used by day care centers to transport wheelchair and disabled patients, (h) nutrition satellite (title VII) program, (i) volunteer program, (j) medical outreach to senior centers and nutrition program, and (k) geriatric education and training program for medical students, house staff, professional staff, volunteers, and others.

The new services being considered to expand the above components into a comprehensive system will include: (a) transition program to help patients discharged from day health program and hospital geriatric services to adjust to more independent living, (b) homemaker services, (c) experimental bed usage including respite care, hospice care, and ICF beds, (d) skilled nursing facility to serve both convalescent and long-term patients, (e) work activity program (a sheltered workshop), (f) protected living arrangement which will pay attention to architectural, personal care, psychosocial supports, (g) training geriatric paraprofessional workers using CETA trainees, (h) develop central intake center for all geriatric services, and (i) developing liaison with existing community agencies, particularly senior centers, nutrition programs, licensed board and care homes, and the San Francisco Department of Social Services.

5. On Lok Senior Health Services—A Community Care Organization for Dependent Adults

This project is funded by the Office of Human Development Services while HCFA is granting certain waivers under medicare and medicaid. The project's overall objectives are: (1) to apply management and reimbursement principles of HMO's to the problem of long-term care by developing a model community care organization for dependent adults, and (2) to evaluate the impacts of this organization on the quality and cost of long-term care, and on the health and welfare of persons who would have been institutionalized. The grantee is the California Department of Health.

This project grows out of two demonstrations funded by the Federal Government. The first demonstration covered the development and implementation of a day health center with emphasis on medical, psychosocial, and supportive services. This experiment evolved into a health services network as a result of grant support from AA. In-home supportive services as well as a social-health maintenance center (a cross between a day health center and a senior citizens center) were provided. With HUD support, the On Lok organization is building a housing facility within which health services will be provided. A social worker/advocate coordinates and supervises service delivery within the program and arranges for services not covered under the program.

The proposed project expands the health services network to include the availability of a complete range of services both acute and long term to program participants. Most clients are functionally dependent adults living alone or in institutions. A HMO-type organization will be established. Enrollment will be determined by need for social or health services, and the On Lok center will assume complete responsibility for managing or delivering services.

On Lok will continue to provide day health and social health maintenance services. They will also provide home health and chore services, portable meals, primary medical care, and will be responsible for the delivery and payment of ancillary medical services. When fully developed (at the beginning of second demonstration year), the project will be responsible for the cost of acute and long-term institutional care. In addition, On Lok staff expect to help participants find adequate housing and, for those needing more sheltered care, place participants into the On Lok housing facility. Finally, within the first 2 years of the project, a hospice program will be developed.

The project proposes to develop a prepaid capitation system to finance service delivery. While On Lok will be at risk during the first project year, during subsequent years, reimbursement will be at cost. The project expects to demonstrate savings using the HMO approach by reducing nursing home days, physician costs, and in-home and other supportive costs.

6. Evaluation of New York State's Long-Term Home Health Care Program

The New York State Department of Social Services is expanding the services in the home being funded under the title XIX (medicaid) program through waivers of some medicaid program requirements. Moreover, HCFA will be conducting an evaluation of the overall New York State long-term home health care program during 1979.

This project involves a single source, single entry system which has been designed to offer high quality home health services through long-term home health care programs (LTHHCP). These have been mandated under legislation passed in 1977 an deffective April 1, 1978. Home care will be an alternative to institutionalization for medicaid eligible functionally impaired patients who meet the medical criteria for skilled nursing or intermediate care levels. The budget for the home-based services may not exceed a maximum 75 percent of the average monthly rate payable for nursing home or intermediate care, whichever it the appropriate level for the individual, within the social services district.

The New York long-term health care programs are viewed a sa unique opportunity to develop and evaluate a distinct new delivery system for noninstitutional care. It is aimed a ta well-defined population with the expectation that data will be available on both patients and providers. Comparisons will be possible for the delivery of comprehensive home health care under four different models: Public or voluntary hospital-based public or voluntary skilled nursing facility based, public or voluntary health related facility based, and home health agency-based long-term home health care programs. The program will demonstrate the effectiveness of case management for the health plan of care provided by an employee of the long-term home health care agency. Coordination of services available through funding sources other than title XIX will be provided by the local social services district.

RESEARCH ACTIVITIES

Research in long-term care is directed at analyzing various elements of the current system, obtaining data on recipient, cost, providers, and services, and applying analytic theories to behavior of providers and patients under the current system.

Current research activities in HCFA include these:

—As part of a grant to the University Health Policy Consortium, headquartered at Brandeis University and including Boston University and the Massachusetts Institute of Technology, a variety of policy relevant analytic activities will take place. Papers are being developed by the consortium that analyze medicaid level of care issues, develop options for large-scale long-term care reforms, provide background on the role of the family in long-term care, and address a number of other issues of provider, system, and patient behavior. These activities will be expanded in the coming year.

—A grant to the University of Colorado Medical Center will study long-term care reimbursement and regulations. This project will develop refined measures of case mix, quality, and cost in nursing homes. It will also develop a means of integrating these variables in an effort to develop new methods of reimbursing and regulating long-term care services.

—With the aid of the Census Bureau and its data, we are attemping to expand and improve our baseline data on the aged, their living arrangements, long-term care facilities, and costs of care.

INDIVIDUAL PROJECT SUMMARIES—ONGOING

1. Reimbursement

a. Prospective reimbursement for nursing homes

The objective of this study is to develop a formula prospective reimbursement system for nursing homes. The research design calls for the development of a behavioral model of the industry which identifies the degree and direction to which the nursing home operator responds to a variety of mechanisms established by the rate setter and other regulators. The study is designed to provide information about these responses, with particular attention to incentives and penalties implicit in prospective rate-setting methods. The end results of this study will be a list of policy choices with their implications for public budgets, cost containment, availability of care to public patient, and other public objectives, as well as a prototype formula PR system.

b. Risk and rate of return on equity capital

This project by Battelle examines and analyzes the effects of reimbursement policies on the profitability of the nursing home industry. It does so by focusing on four major areas: (1) Examination of the effects of varying State medicaid policies on the growth in nursing home beds and the change in nursing quality; (2) calculation of accounting rates of return to determine systematic differences across four States and across facility classifications; (3) examination of the risk inherent in the industry and its relationship to measurable financial characteritics of the industry; and finally, an attempt to measure whether vertical and horizontal integration is positively related to profitability or not. These studies have been designed with a view to improving the understanding of how the reimbursement systems affect the profits and growth of nursing home industry, and to produce research products which will directly help to determine the proper method for setting returns on equity capital in a formula based prospective reimbursement system for nursing homes.

c. Case studies of selected States' PR systems

The main task of this project is to study in a descriptive fashion the selected States' experience with prospectively reimbursing nursing homes. The Urban Institute has met with officials from seven States (California, Colorado, Connecticut, Louisiana, Michigan, Minnesota, and New York), and has collected information to perform a number of study tasks. These include an investigation of the formal, informal and perceived goals of each States' PR system; a detailed description of the reimbursement methodology; identification of the formal means by which the regulatory agency gages the impact of the reimbursement system on the industry; and a description of each States' information (data base) system which it may use to establish and monitor the PR system.

2. Alternatives

a. Methodology for finding, classification, and comparing costs for services in long-term care settings

The objective of this project was to develop a cost-finding methodology and classification structure useful for (1) comparing costs and services by patient characteristics, and (2) comparing these costs and service across the spectrum of long-term care alternatives. It has two distinct parts. During phase I, a system of classifying patient characteristics, a consistent set of definitions of costs and services, and procedure for surveying cost, were developed. The "patient profile survey" and the "patient service questionnaire" were developed to collect information to classify patients. The "cost-finding survey" was developed to collect information on costs. Techniques were developed for interpretation of the data collected. The data collection instruments were pretested in nine settings.

In phase II, the methodology was further tested and refined by application of the methodology in 11 different long-term care settings at 29 sites.

b. The feasibility and cost-effectiveness of alternative long-term care settings

The main tasks on this project were to define methods and outline conditions for determining the feasibility of setting up service programs such as geriatric settings, chronic care centers, comprehensive service delivery organizations for extending long-term care to the chronically ill and disabled outside of nursing homes and long-term hospitals.

Its approach called for an in-depth analysis of selected service programs to determine viability for continued operation. Institutional facilities within the same catchment areas were compared with these services to analyze the relative cost-effectiveness of the alternative care setting and the nursing home for populations of like functional capacity. State-of-the-art studies augmented that on-site study.

Concurrently, general analysis of legislative, regulatory or organizational requirements which impinge upon the establishment, operation and payment systems through which long-term care services operate were undertaken. Guidelines for innovators through which the feasibility of establishing services similar to the studies programs were developed.

FUTURE DIRECTIONS

During fiscal year 1979 HCFA is continuing to review applications for demonstrations and research. The fiscal 1979 and 1980 activities planned represent refinements and expansions in the scope and methods of HCFA's research and demonstration activities. The focus in 1979 will be to develop greater capability to carry out a more extensive program in 1980. This program will include: (1) collecting basic economic information needed for monitoring the spiraling expenditures in the long-term care industry (now increasing faster than hospitals); (2) developing a long-term care data base to detect fraud, abuse and error in the Federal programs; (3) collecting reliable information on the costs, utilization and need for long-term care service for medicaid and medicare patients, (4) determine the cost-effectiveness of noninstitutional long-term care services; (5) testing different methods for delivering, organizing, and financing long-term care services in a comprehensive and coordinated system; (6) testing alternative reimbursement methodologies for long-term care institutional and non-institutional services; and (7) developing reliable information necessary to make informed decisions about long-term care coverage under a national health plan, including research on congregate living arrangements.

Finally, in 1979, HCFA will be funding, through the medicare and medicaid waiver authorities, a number of demonstrations of the hospice concept. The focus will be on hospices which are primarily home care programs, although they may have an institutional arrangement as a backup for short-term care. The objectives of these projects are (1) to experiment with alternative service and delivery systems, and (2) to determine whether the medicaid and medicare programs can realize cost savings by providing services to terminally ill patients in a home setting rather than in hospitals and nursing facilities.

HEALTH RESOURCES ADMINISTRATION

Program Activities in the Manpower Area of Aging—1978

Special emphasis was given in the Nurse Training Act of 1975 to the problems and health care of the aging. Grants and contracts were authorized for special projects to improve curricula in schools of nursing for geriatric courses and to assist in meeting the costs of developing short-term inservice training programs for nurses aides and nursing home orderlies. The latter programs emphasized the special problems of geriatric patients and included training for monitoring the well-being, feeding and cleaning of nursing home patients, emergency procedures, drug properties and interactions, and fire safety techniques. Under section 822 of the Public Health Service Act (PHS Act), grants and contracts were authorized to educate nurses in the provision of primary health care to the elderly. The following active projects, which are expected to amount to over $4 million during their 3 years of support, provide nurse practitioner training support in primary care for geriatric patients.

Applicant	Title	Fiscal year 1978 support
University of Pittsburgh, Pittsburgh, Pa	Adult, family, geriatric nurse practitioner (certificate program).	$124,962
State University of N.Y. Upstate Medical Center Syracuse, N.Y.	do	101,903
University of Utah, Salt Lake City, Utah	Specialist in gerontologic nursing—master's program.	20,651
University of California, Davis, Calif	An education network for nurse practitioners-family geriatric (certificate, master's option).	227,462
University of Miami, Coral Gables, Fla	Geriatric nurse practitioner (certificate program)	147,272
Cornell University—New York Hospital, New York, N.Y	Training program to prepare geriatric nurse practitioners (certificate program).	112,858
University of Wisconsin, Madison, Wis	Pediatric and geriatric nurse practitioner training (certificate, master's option).	243,864
Seton Hall University, South Orange, N.J	Gerontological nurse practitioner program (master's degree).	127,764
California State University, Long Beach, Calif	Nurse practitioners: A cooperative project (master's degree).	146,017
Columbia University, New York, N.Y	Development of leadership programs in primary care (pediatric, adult, geriatric) (master's degree).	372,422
University of Lowell, Lowell, Mass	Graduate program: Gerontological nurse practitioner (master's degree).	133,844
Boston University, Boston, Mass	Nurse practitioner/clinician gerontological nursing program (master's degree).	114,462
Emory University, Atlanta, Ga	Gerontologic nurse practitioner (certificate program)	98,757
University of Kansas, Kansas City, Mo	Primary care nurse practitioner—maternal child health, rural, adult geriatric (certificate program).	160,950
Total		2,133,188

Other 1978 activities include a $151,431 contract to plan, develop, implement, and test a model inservice course of instruction not to exceed 6 months for nurse's aides and orderlies employed in nursing homes that care for the geriatric patient. Westbrook College (Portland, Maine) received a continuation award ($26,676) for a grant to provide basic instruction in the skills of caring for the geriatric patient in long-term care facilities and to enhance a deeper concern and awareness for the elderly patients. A grant was also made to Emory University ($165,281) in 1978 to support a 3-year proposal ($512,032 total) to support nontraditional community based clinical practice settings. This project will improve teaching effectiveness of nurses to meet the health needs of underserved population groups, including the elderly. Donnally College in Kansas City received a project grant ($51,142) to upgrade the skills of aides and orderlies to assure concerned and efficient care of the elderly (3-year project totaling $101,776). The Miami Jewish Home and Hospital for the Aged has a special project grant to provide training and education to upgrade the skills of paraprofessional nursing personnel that care for the elderly in nursing homes. In addition, the following 3-year (4 years for University of Virginia) advanced nurse training grants (section 821, PHS Act) focus in whole or in part on gerontological nursing:

Applicant	Title	Fiscal year 1978 support
Duke University, Durham, N.C	Expansion of graduate nursing program	$145, 708
University of Rochester, Rochester, N.Y	Graduate concentration in gerontological nursing	107, 768
San Jose State University, San Jose, Calif	Gerontological nursing specialist program	85, 434
University of Virginia, Charlottesville, Va	Expanding medical-surgical nursing program	182, 305
University of Kansas, Kansas City, Kans	Training of gerontological clinical nurse specialist	125 781
University of San Francisco, San Francisco, Calif	Graduate program in long-term/gerontological nursing.	150, 015
University of Pennsylvania, Philadelphia, Pa	Gerontological nurse clinician	75, 753
University of Kentucky, Lexington, Ky	Gerontological nurse training grant	12, 231
George Mason University, Fairfax, Va	Master of science in nursing	103, 976
Case Western Reserve University, Cleveland, Ohio	Post-baccalaureate program in gerontological nursing.	122, 354
Montana State University, Bozeman, Mont	Nursing specialist for underserved rural areas	119, 802
Indiana University, Indianapolis, Ind	Expansion of a doctor of nursing science program	106, 988
Total		1, 338, 115

Four of the nursing research grants receiving funds during fiscal year 1978 focused on the care of elderly patients. Wayne State University Institute of Gerontology received $25,971 ($51,461 total) to evaluate the job performance of registered nurses and nursing aides in nursing homes. Pennsylvania State University received $48,099 ($82,394 total) to examine the effectiveness of operant behavior theory and technology in optimizing self-maintenance and social activity in elderly nursing home residents. The University of Miami School of Nursing received $36,986 to test the influence of organizational context on nurses' attitudes toward the aged. Last, the University of Rochester School of Nursing was awarded $74,000 to identify methods of working with the elderly to maintain socialization and activity levels.

Active allied health special project grants include (1) University of North Colorado for training in geriatric aural rehabilitation ($34,528 for fiscal year 1978; $193,734 for prior 2 years), (2) Quinnipiac College (Hamden, Conn.) for coordinated education leading to licensure in long-term care (LTC) administration ($29,586 for fiscal year 1978; $122,980 for prior 2 years), (3) State University of New York at Stony Brook for gerontology curriculum development to train students in the School of Allied Health Professions at both the undergraduate and graduate levels ($30,343 for fiscal year 1978; $75,496 for prior 2 years), and (4) University of Texas for gerontology services administration program at the certificate and baccalaureate level $(44,830 for fiscal year 1978; $40,171 in prior year).

Yale University was awarded a 3-year public health special project grant for long-term care planning, evaluation, and policy analysis ($30,240 in first year). A $457,835 contract to the University of Pittsburgh for word toward a baccalaureate external degree in health services administration-LTC administration major was completed in December 1978. A contract was awarded in September 1978 to the Center for Human Services (Washington, D.C.) to identify the needs of the elderly that are pharmaceutically related and to propose alternative methods of alleviating needs that are not being met through educational programs for pharmacist and pharmacy students (estimated cost $92,036). Eight of 12 contract totaling $618,746 for LTC training programs (one an evaluation) were completed in late fiscal year 1978. Other ongoing contract/grant activities which have some impact on the aged, although less direct, involve such areas as curricula, delineation and verification of functional roles, and student support.

Under the family medicine authority (section 786, PHS Act) and the primary care training authority in internal medicine (section 786, PHS Act), some grantees have requested funds to support programs which incorporate geriatric training concepts. Several faculty development grants offer specific geriatric training to family medicine faculty. Under section 781(a), the University of Maryland School of Medicine received a $670,470 contract to develop an area health education center program which includes graduate and undergraduate geriatric medical training in an urban geriatric setting. The University of Nebraska, under section 783 of the PHS Act, received a 3-year grant for $412,000 which emphasizes geriatric education in physician's assistant training. This grantee has completed a syllabus for the gerontology clerkship and has developed an evaluation plan for the gerontology curriculum.

A working relationship has been established with representatives of the National Institute on Aging, the Veterans' Administration, and the Administration on Aging. An internal staff paper entitled "Current and Future Needs in Geriatric Education" has been approved for publication. It will appear in the January-February 1979 issue of Public Health Reports which has a distribution to 14,000 people including researchers, public health practitioners and educators. Another ongoing activity is the development of a national and international knowledge bank or geriatric activity.

Methodologies and survey techniques have been developed by the University of Michigan under contract to study the effect of community water fluoridation on the demand for dental care among older adults. A study, which is now in the planning phase, will utilize the methodologies to help assess current and future dental health needs among elderly populations. The provision of adequately trained professionals available to deliver primary dental care services to the geriatric patient who is in an institutionalized, noninstitutionalized, or home-bound setting is a major target area. Traditional delivery methods do not always provide access to dental care to many of these individuals both in terms of availability and cost. Training support is available through special project grants; general practice residency programs, which, in some instances, are in hospitals providing comprehensive dental services to the elderly; and in the capitation program which has an extramural training requirement that students receive a portion of their training directed at unserved population groups that include the elderly. Technical assistance has been provided to the State of Oregon (State Health Department and Portland Community College) and $61,293 to the State of Maine (State Dental Board and the University of Maine) to explore the potential cost and accessibility benefits of the wider use of denture technicians in the fabrication of dentures for the elderly. These efforts will help the two States develop training programs for dental auxiliaries in selected clinical and nonclinical procedures related to denture construction.

HEALTH PLANNING

To support the responsibility of the Administration on Aging for carrying out a major Federal law affecting the lives of the elderly, the Health Resources Administration, through the Bureau of Health Planning, entered into an agreement with the AOA for purposes of coordinating Federal activities to improve the health and medical care services to older Americans. This coordination has taken place throughout many of the States through the development of agreements between individual health systems agencies and area aging agencies in terms of carrying out cooperative and mutual support activities in data sharing, development of area plans for the identification of needs of the elderly population, assessment of the services and resources affecting those needs, and exchange of technical assistance. Health planning staff in the DHEW regional offices are coordinating with regional aging directors and are monitoring health systems agency governing body membership rosters to determine that the aging population interests are represented.

The Health Resources Administration welcomes the opportunity to encourage the further development of planning functions taking place in the aging agency network with the planning activities of the local and State health planning agencies to assist in meeting the requirement of the Older Americans Act Amendments of 1978 (Public Law 95-478), that the Commissioner of AOA "shall develop planning linkages with local health system agencies (as defined under the National Health Planning and Resources Development Act of 1974)."

HEALTH SERVICES ADMINISTRATION

INTRODUCTION

There are numerous denfinitions of "aging." From a biological viewpoint, aging is defined as a process of progressive deterioration of organic function which varies from individual to individual. However, definitions of aging in terms of Federal law apply to calendar year criterion as the means of determining eligibility for health and social services. Currently, health care entitlement acts, such as medicare, impose a minimum age criterion of 65 as one of the means to determine eligibility for health care benefits. At the same time, other Federal programs such as the Older Americans Act use a calendar year cutoff of 60 years and older as the means of determining eligibility. Similarly, private industry has traditionally applied a calendar year definition, usually 65 years, as a means to determine eligibility for retirement benefits. It seems, however, that changing social norms coupled with the fact that the U.S. population is growing older may alter existing concepts and concurrent definitions of aging. Such possible changes are considered in projecting the long-range need and demand for health care services provided by the Health Services Administration (HSA).

The HSA has adopted the calendar year definition of aging which conforms to the 65 year and older criterion to describe the scope and extent of the past and planned use of health care services by the "aged" population. This is, in part, due to the present definition of aging cited in the Medicare Act. However, changes in current concepts of the aging process expressed in terms of modification to existing legislation may drastically alter both statistical projections of health care need, subsequent projections of health care need, and subsequent projections of demand for health care services.

SERVICES PROVIDED IN 1978

Health care services provided in the health centers, clinics, hospitals, and other delivery settings which comprise the HSA delivery network are available to the aged population as part of a broader beneficiary population served by HSA programs. In the vast majority of cases, age is not a factor in determining HSA program eligibility for individual health care services. However, the HSA has aggressively pursued a policy of responding to serious deficiencies in the provision of health care to designated population clusters or groups who reside in medically underserved rural and urban areas. This is evidenced in the age emphasis of some HSA programs such as family planning, maternal and infant care, and child health.

In terms of the age distribution of HSA program users, the elderly individual represents a relatively small percentage of those receiving health services. Despite this fact, HSA has long recognized the need to adequately respond to the health needs of the aged. This recognition is reflected in the criteria used by HSA to identify medically underserved rural and urban areas. In determining medical underservices, four factors are taken into consideration: (1) the proportion of aged people in the area; (2) the proportion of poor people; (3) the number of doctors in the area; and (4) the infant mortality rate. Use of the number of aged, as well as the poverty factor, focuses attention on the elderly. Activities which impact most significantly on the aged are promoted through the community health centers, migrant health, National Health Service Corps, hypertension, and home health programs supported by HSA's Bureau of Community Health Services (BCHS). This same recognition of responsibility extends to the continuing development of special programs to serve elderly Indians and Alaska Natives. Since 1976, HSA's Indian Health Service (IHS) has supported special health care initiatives for the elderly through its Committee on Aging. Such support continued in 1978 with active IHS participation in the special Indian conference on health convened by the National Indian Council on Aging. The success of PHS hospital geriatric day care center programs supported by the Bureau of Medical Services led to further expansion of such centers throughout the PHS hospital network. Specific HSA program emphases in 1978 are briefly summarized below.

Community health centers

In 1978, there were 3,047,250 people who received a range of preventive, curative, and rehabilitative services in 592 community health centers. Of the number of people who received such services, over 7 percent were 65 years or older. By the end of fiscal year 1979, there are expected to be 756 community health centers serving approximately 3,697,000 people. Satellite community health center clinics have been established in areas of high concentration of elderly individuals, such as housing projects for the elderly. The satellite clinics provide podiatry, dental, mental health, emergency (ambulance), multiphasic screening, and a variety of medical outreach and home health services for the aged. Some center grantees also initiated formal linkages with AOA- and USDA-supported social and nutritional programs. These include the food stamp program, meals-on-wheels projects, and social-recreational services such as escort shopping. Such linkages also extend to home health agencies, State and county health departments, transportation arrangements with long-term care institutions, and a broad range of individual center service arrangements with nonprofit senior citizen organizations.

Migrant health program

The migrant health program provides access to health care services for migrant and seasonal farmworkers and their families. Migrants live and work in predominantly rural areas where health resources are scarce. Although they face problems of shortage and maldistribution of health resources which other rural residents must cope with, the migrants' problems are compounded by such factors as the need to travel from place to place in search of work and language and cultural differences. In addition, the elderly migrant is further handicapped by the multiplicity of problems which accompany aging. In 1978, services were provided at 314 sites (144 projects) to 557,000 migrants and seasonal farmworkers and their families. Of the number served, 4.2 percent were 65 years of age or older.

The National Health Service Corps

The National Health Service Corps was designed to improve the delivery of health services to persons residing in communities where health resources are inadequate or nonexistent. The approach is to: (1) Recruit and place health professionals in those areas; (2) assist the communities in developing the capacity to independently maintain their own systems of care; and (3) design policies that will encourage health professionals, once placed, to remain in shortage areas on a non-Federal basis. Beacuse older people residing in these areas often have reduced mobility, the presence of health personnel in their communities is of special importance. A total of 725,825 people was served by 1,289 providers at 668 sites in 1978. It is estimated that 9 percent of the people served were 65 years or older. The National Health Service Corps has been successful in placing an increasing number of corps' medical staff in community health centers, migrant health, and like programs.

Home health program

Another area of continued expansion, the home health program, is specifically directed toward meeting the needs of the aged. The home health program is responsible for building the Nation's capacity to provide home health services and to improve the quality of care provided. Home health agencies are designed to offer health care services which are often cost-saving alternatives to institutionalized care in hospitals and nursing homes by attempting to maintain elderly persons in their own homes. In awarding project grants funding, priority is given to areas in which a sizable proportion to be served are elderly, medically indigent, or both. In 1976 and 1977, 85 percent of the grants were awarded to areas with a high proportion of elderly, and in 1978 the percentage was increased to 90 percent. HSA's Bureau of Community Health Services, within 3 operational years of the home health program, has awarded 206 grants for either the development of new agencies or the expansion of existing agencies. As a result of the grant program, home health services are now being provided to 135 counties that were not previously served by a medicare-certified home health agency. Home health services were expanded in an additional 446 counties with a population of 36.5 million persons. Preliminary data indicate that those home health agencies awarded grants in 1976 were able to expand the medicare population served by 140 percent and that the total population served was expanded 300 percent. Twenty-one training grants were awarded in 1978 to train home health aides who are or will be employed by medicare-certified home health agencies. It is projected that those 21 grantees will be responsible for training 3,000 home health aides to provide services to a caseload which is predominantly 65 years and older.

Hypertension

The HSA has recently expanded its focus on hypertension which affects a significant proportion of the aging population. Program efforts include screening, detection, diagnosis, prevention, and referral for treatment of hypertension. This activity is concerned with identifying persons with hypertension and helping to assure that they establish and maintain a proper, medically supervised treatment program. Guidelines have been published for the development and operation of State hypertension programs. Technical assistance is available to provide guidance to State and local health departments in developing community-based high blood pressure control programs. Where feasible, the local health departments have been encouraged to coordinate their activities with other Federal agencies and voluntary organizations which share similar responsibilities; for example, American Heart Association. The HSA participated with the national high blood pressure education program in the national campaign for high blood pressure control in distributing material during the month of May. Educational material for both the public and health professionals was distributed to approximately 6,000 projects. In addition, this material was printed in Spanish for distribution to those projects serving predominantly Hispanic-speaking populations.

The Indian health program

The Indian health program served approximately 498,000 Indians and Alaska Natives, many of whom reside on the 250 reservations and Indian communities located in 25 States and hundreds of villages in Alaska. Based upon the 1970 U.S. census, persons aged 65 and over comprised 6 percent (30,000) of the U.S. Indian and Alaska Native population. A comparison with the national percentage of those 65 and over (10.5 percent) in 1975 indicates that the U.S. Indian and Alaska Native people are relatively young. Thus, a major objective of the Indian Health Service in 1978 was to continue to advance the health level of the young and maintain the health gains of the previous decade (1960–70) which would achieve a larger older age segment of the Indian and Alaska Native population with improved health status. For example, program emphasis from 1960 to 1970 was directed toward those in the younger age group. As a result of focusing scarce resources to meet the many health needs of the younger population, the number of Indian and Alaska Native persons aged 65 and over increased by 39 percent as compared to 29 percent of the U.S. population during the 10-year period of 1960 to 1970. By fiscal year 1978, 2,500 elderly persons had used their medicare entitlement in Indian Health Service facilities for the first time.

Specific services were provided which sought to minimize the health problems of the aged. These services included continual identification by all members of the IHS staff of the health needs of the aged which included social assessment of the needs of the family and the lone elderly by IHS-trained Indian and Alaska Native social work associates, community health representatives and aides, and public health nurses. Such efforts focused on seeking out the elderly to provide them with access to health care resources with appropriate counseling which would bridge the differing cultural concepts of illness and preventive medicine. These efforts were complemented by IHS medical and social service surveillance for nursing home and extended medical care patients, assistance in obtaining services under medicare, medicaid, the USDA-administered food assistance program, Veterans' Administration, and other Federal and State programs.

Support for the 1978 Indian Conference on Health of the Elderly conducted by the National Indian Council on Aging was also provided by HSA's Indian

Health Service. Four background papers funded by IHS were used as a frame of reference for Conference workshops. These included: (1) "Physical and Mental Health of Elderly American Indians," (2) "Alternatives for Planning a Continuum of Care for Elderly American Indians," (3) "The Environment of Elderly Native Americans," and (4) "Data and Materials to Support a Community Education and Safety Program to Reduce Accidents Among Elderly Indians." The background papers have been distributed widely and placed in key libraries to provide benchmark data for future assessments of needs and accomplishments.

Support efforts have also included the preparation of descriptive pamphlets on a variety of tribally sponsored programs for the aging. These pamphlets have encompassed such topics as: (1) "Assessment of Needs and Recommendations for a Service Delivery System for the Elderly" (Pueblo of Laguna Planning Commission); (2) "Northern Chyenne Elderly Program" (the Wendell Shoulderblade Center); (3) "Services to the Elderly" (the Sisston-Wahpteon Sioux Tribe of the Lake Traverse Reservation); (4) "Yakima (Washington) Tribal Health Surveillance Program". and (5) "Oneida (Wis.) Nursing Home." An urban project (Tucson, Ariz.) was described as well. The documented experiences of these rtibes serve as models for development elsewhere.

Public Health Service hospital care

Health care services within HSA's Bureau of Medical Services (Division of Hospitals and Clinics) are provided by 9 PHS hospitals (8 general medical-surgical and 1 specialty hospital for the treatment of Hansen's disease), 27 free-standing outpatient clinics, and more than 300 contract physicians and hospitals located throughout the United States. While it is known that all of the USPHS hospitals and outpatient clinics treat persons aged 60 and over, precise data regarding the number and services rendered ot this age group on an outpatient basis cannot be obtained at this time. During the first 6 months of fiscal year 1977, of the 16,418 discharges from the USPHS hospitals, in 4,490 instances, the patient was 60 years of age or over. Annualized, it is estimated that approximately 161,000 patent-days were utilized by this group at an estimated cost of $22,862,000 based on an average daily rate of $142. The average length of stay for this age group is somewhat longer than for younger individuals. American seamen constitute a major PHS beneficiary group, and there are probably more single males in this category than in the population at large. As a consequence, finding suitable nursing homes or other protective settings constitutes one of the major difficulties in discharge planning.

Hospital-based geriatric day treatment and screening and referral services

The Geriatric Day Treatment Center (GDTC) has been operating on the campus of the USPHS Hospital, Baltimore, Md., since January 1976. It is jointly sponsored by the Family and Children's Society of Baltimore and the USPHS Hospital. Through a contract with the Maryland State Department of Health and Mental Hygiene, Office of the Chronically Ill and Aging, the GDTC received title XX funds. Each year the program has been in operation, the title XX funds have increased. This program provides an alternative to institutionalization, and services are delivered by a multidisciplinary staff in a protective group setting. The program is structured around an organized regime of activities of daily living (ADL) and health services. Additional important program components include nutrition counseling, psychiatric consultation, and transportation. Family members are counseled and taught various techniques to increase their ability to be helpful to the program participant in the home. Program participants are persons 60 years of age and older referred from PHS beneficiary groups, the geriatric evaluation service of the Baltimore City Health Department, community organizations, and private physicians.

The GDTC program continues to grow and develop. Most of the program participants have multiple chronic diseases and/or handicaps and the GDTC continues to increase its capacity to treat severely impaired patients, especially those with communication difficulties or problems with psychiatric overtones. The psychiatry department of the Baltimore USPHS Hospital works closely with the center staff to offer staff consultation and to actively participate in patient management. About 75 percent of the program participants are in wheelchairs.

When the GDTC was established it was anticipated that it would offer extensive opportunities to serve as a demonstration model and research laboratory in the development and operation of day care programs for older persons. This aspect has been realized through the consultation and technical assistance that the GDTC has been able to offer to staff at several other USPHS hospitals, associates working on various levels of local and State government and colleagues who are program managers of other geriatric programs in Baltimore and in other parts of Maryland. The staff of the GDTC consider these professional responsibilities an important part of the program's function so these activities have continued and become more extensive. Contributing to the growth and development of new professionals is also considered to be an important function of the GDTC. Nursing, occupational therapy, and social work students from the University of Maryland, Towson State University, Morgan State University, and the Community College of Baltimore are regularly assigned to the GDTC for field work experiences.

During fiscal year 1979, the GDTC expects to be able to again double the number of program participants. The staff is eagerly looking forward to the completion of renovations to an adjacent building which will double the space available for delivery of patient care services. The GDTC will then have approximately 8,000 square feet of space available for the program.

The USPHS Hospital in San Francisco has operated a geriatric screening and referral service (GSRS) since 1977. This program was developed with several community groups and the San Francisco Health Department to examine persons 60 years of age and over who live in the Richmond and Sunset districts of San Francisco. The goal is to maintain people at the highest level of functioning and self-sufficiency as possible. The staff includes a nurse practitioner and is made up of persons from the USPHS Hospital and the San Francisco Health Department. Program participants receive a complete history and physical examination, laboratory workup, social work interview, and immunizations as appropriate, for example, flu vaccine. They are referred for eye and hearing examinations and for other services as needed. Scope of services also include followup on an annual basis and more frequently if indicated. The GSRS works very closely with the San Francisco District 5 Community Board which has a geriatric protective service and with the Richmond RAMS group which is a multilanguage, mulitcultural, yet predominantly Chinese, mental health program. The GSRS clinical sessions are held once a week and see 5–10 persons per clinic session.

Hospital-based nutrition programs

The USPHS Hospital in Boston established its nutrition program for the elderly in 1977. This program regularly serves lunch to about 75 people 60 years and over, 5 days a week. In addition to lunch and the associated socialization, nutrition information and counseling are integral parts of the program. On an as-needed basis, program participants have received other health care services from the hospital, such as physical examination and treatment and optometry services. Recently the hospital was able to obtain some support for the program from an outside agency by negotiating a contract with the Commonwealth of Massachusetts to be reimbursed 36 cents per meal.

Clinical research studies

Funds for clinical research studies are distributed through the Central Clinical Investigations Committee of HSA's Bureau of Medical Services, Division of Hospitals and Clinics (DHC), a formally constituted body that is also responsible for monitoring and evaluating research programs. During fiscal year 1978, the DHC funds allocated for clinical research totaled $374,144 of which $98,887 was for research in Hansen's disease and $206,271 was allocated to research related to aging or the aging process. During fiscal year 1978, 39 clinical research projects related to aging were operational in five USPHS hospitals (Baltimore, Boston, San Francisco, Seattle, and Staten Island).

SERVICES TO BE PROVIDED IN 1979

The program activities undertaken in 1978 will be continued to adequately serve the aged. The success of such past efforts will also serve as the basis for a new demonstration program for the aged. A joint agreement between HSA and the Administration on Aging (AOA) has been developed and is scheduled for implementation in 1979. This HSA–AOA program will link health care resources with social services to effectively address the unmet health and social service needs of the elderly.

The agreement between HSA and AOA focuses on the planning and delivery of a comprehensive package of health care and social services to the aged. Ten demonstration projects will be selected and funded to establish model operational linkages between HSA and AOA programs. The AOA and HSA will select three demonstration projects from IHS, two projects from BMS, and five from BCHS. The IHS projects will incorporate the program activities and priorities established during the 1978 Indian Health Service Conference on Aging. The BMS projects will involve the funding of two demonstration projects which focus on the elderly residing in the immediate geographic area served by two USPHS hospitals. Five BCHS primary health care projects will also be selected to serve as demonstration models. The BCHS projects will seek to demonstrate effective ways of linking primary health care delivery sites with area agencies on aging.

The 10 demonstration projects share the common goal of improving the availability and accessibility of services for the chronically impaired and frail adult. HSA and AOA will be developing appropriate project guidelines for granting awards to communities for demonstration of effective ways of linking health and social services. The HSA-AOA agreement is designed to achieve a series of operational and programmatic goals over the next 3 years. All of these goals focus on the demonstration of effective means of improving the quality and comprehensiveness of services to the elderly.

NATIONAL INSTITUTE ON AGING

DEVELOPMENTS IN AGING

One of the most important contributions that aging research has had to make to society is the demonstration that aging and disease are not one and the same. The acceptance of this distinction marks the dissolution of the stereotyped view of old people as diseased and decrepit, a view that once pervaded not only the health care system, but the social fabric of our country as well. Geriatric clinicians know the dire consequences of such prejudicial attitudes toward elderly patients: Treatable illnesses are ascribed to the supposedly "untreatable" process of aging. Often, apparently disoriented patients are labeled "senile" and sent home, when the disorientation may be a symptom of infection or some other condition that has stressed the individual's cerebral circulation. Conditions such as these can often be managed or even cured, at substantial cost savings when compared to lengthy commitments to long-term or home care. The mistaken belief that the diseases afflicting many elderly persons are unavoidable extensions of the aging process can be a self-fulfilling prophecy—a person who has been labeled "senile" may begin to think of himself or herself in those terms, and act accordingly.

Research on both the medical and social problems of the elderly can reduce the costs of serving them. For example, if we discover means of lessening the physical and mental deficits that can be caused by disease, we will have changed the needs of the patient for medical, social, and other services. By the same token, if we change the socioeconomic circumstances of the elderly, we may also change their needs for certain services.

Research on aging is multidisciplinary, for the demographics of our aging population have an impact on all aspects of the quality of life and on the costs for health care and social services. The over-65-year-old group is expected to increase in size from 23 million in 1976 to 32 million in 2000, and then to 45 million by 2020. All age segments of the elderly population are expected to grow rapidly, but particularly the extremely aged, so that in the year 2000 there will be about 17 million persons 75 and over, and about 5 million who are 85 and over. Since the very old are the most frequent users of the health care system, we must prepare now so that we will be able to meet their needs as their numbers grow.

The broad mandate of the National Institute on Aging (NIA) reflects this need for a multidisciplinary approach to the study of aging. Among the NIA's many areas of interest are the following, which received special emphasis during 1978:

Treatable Brain Diseases

"Senility"—The most frightening specter of old age—is not an inevitable consequence of growing old; in fact, it is not even a disease. Rather, "senility" is the word commonly used to describe a large number of conditions with an equally large number of causes, many of which respond to prompt and effective treatment. The symptoms characteristic of what is popularly called "senility" include serious forgetfulness, disorientation, intellectual confusion, and certain other medical and emotional disturbances. Although doctors and patients alike have traditionally dismissed these symptoms as incurable consequences of old age, they are not. Thus, it is imperative that a complete, careful investigation of the source of these symptoms be made so that proper treatment can be initiated. Some 100 reversible conditions may mimic a few irreversible brain disorders (such as cerebral arteriosclerosis, senile dementia, and Alzheimer's disease). A minor head injury, a high fever, improper nutrition, or adverse drug reactions, for example, can temporarily interfere with the supply of blood and oxygen to the brain and thus inhibit the normal functioning of extremely sensitive brain cells. If left untreated, such medical emergencies can result in irreparable damage to the brain, and possibly even death.

To draw physicians' attention to the danger of accepting the stereotype of the old as "senile" and of the need for providing effective treatment to the aged, the NIA and the Fogarty International Center (FIC) brought together experts in the fields of internal medicine, neurology, psychiatry, epidemiology, radiology, psychology, geriatric medicine, and general medicine for a consensus development conference on treatable brain diseases in the elderly. Throughout the course of the 2-day conference, discussion focused on several basic questions, including: (1) What is dementia? (2) How common are treatable brain diseases which cause cognitive impairment? (3) What information should physicians have to obtain the most comprehensive and useful history of impaired patients? (4) What is the best kind of physical examination to carry out in impaired patients? (5) Given a diagnosis of irreversible brain disease, what is the physician's responsibility to both the patient and the family?

Having examined these issues at the meeting, the NIA is now preparing a summary document to be circulated throughout the medical community to achieve final consensus. When this phase of the consensus process is completed, the Institute will begin the task of disseminating the consensus position to all health care practitioners.

The Last Days of Life

Because mortality is now associated primarily with old age, the NIA is especially concerned about the quality of the last days of life. When our Nation was founded—just a little over 200 years ago—only 20 percent of newborns survived into old age. Today, the reverse is true: 80 percent of newborns survive into old age, while only 20 percent do not. This shift in life expectancy is largely by result of triumphs over maternal, childhood, and infant mortality, although advances in cardiology and other aspects of health care have led to decreased mortality in later life as well.

The gathering force of what is referred to as the "hospice movement" has served to focus long-overdue attention on how we as individuals and as a society deal with death. The result has been a more humanistic approach to the care of the terminally ill. There are at least four elements which are crucial to hospice care:

- —Educating and training medical, nursing, and allied health personnel to be sensitive to the rights, needs, and problems of those in the last days of life;
- —Discovering new therapies for managing pain and other discomforts of the terminally ill;
- —Providing home care, so that people can remain at home for as long as they desire, and be able to die at home if they wish and if it is possible; and
- —Attending to both the immediate and long-term needs of grieving survivors.

Training programs must not neglect the many volunteers whose dedicated efforts have played an essential role in hospice development and home care. The services of these volunteers add immeasurably to the all-important humanity of a hospice. Therefore, volunteer training and orientation programs must be carefully designed to properly sensitize volunteers to the extraordinarily demanding, albeit rewarding, nature of hospice work.

The issue of the palliative management of pain is now being studied by an Interagency Committee on New Therapies for Pain and Discomfort. Representatives from the National Institutes of Health; the Alcohol, Drug Abuse, and Mental Health Administration; the Health Care Financing Administration; the

Food and Drug Administration; the Department of Defense; and the White House will consider ways to evaluate drug administration practices and patterns, examine the psychosocial aspects of death and dying, and alter practioners' approaches to health care so that they deal with dying patients in terms other than the curing of disease.

As a part of its research program, the NIA has identified the pharmacology of aging as a priority area. We know that the body handles drugs very diferently at different periods of life. he NIA has already cosponsored a workshop on the state of knowledge on age-related changes in response to drugs, and more recently issued a request for grant applications on the pharmocolgy of aging. In the area of pain control, the NIA's interest is focused both on how analgesics act differently in older people and on less traditional, nonpharmacological approaches to pain control, such as acupuncture.

In an effort to understand the immediate and long-term needs of grieving survivors, the Institute recently commissioned a paper on bereavement as a risk factor in mortality. This study, done by Dr. Adrian Ostfeld, professor of epidemiology at Yale University, shows the possibility of an increased death rate of some 25,000 Americans annually as a consequence of significant personal losses they experience. Bereavement is associated with a higher incidence of illness, death, and psychosocial stress. It is clear that we need imaginative, but systematic, studies to understand better the impact of bereavement. In order to encourage scientific work in this area, the NIA has reecntly announced its desire to support additional studies on the nature of bereavement, widowhood, dying, and death, and methods of coping with them effectively. Bereavement requires a variety of adjustments, such as realinements within the family, the development of new intimacies, and changes in relationships with children. Yet few social supports have been developed to assist people at this critical time.

Since we cannot determine where a person will die, nor can the dying person always choose the location of his or her death, the NIA is currently in the process of developing a special epidemiological study of where people do die, under what circumstances (awake or asleep), and to what degree they experience pain. People should not have to live with fears that may be based on an inadequate supply of accurate information regarding the last days of life.

Nutrition and Aging

Proper nutrition may spell the difference between active, productive old people and those who are physically and emotionally disabled and in need of frequent medical attention, hospitalization, and even institutionalization. The NIA subscribers to the NIH-wide position that good nutrition is the cornerstone of preventive medicine. Adequate diet throughout life, including the later years, is an effective means to maintain good health and minimize degenerative changes in old age.

This year, the NIA held a conference that brought some of the Nation's most outstanding clinical nutrition experts together to discuss "Nutritional Needs and Health of the Aging Adult." The goal of this conference was to provide the Institute wih recommended directions for its research program.

It is generally believed (although some argument has arisen in recent months) that as a person ages, he or she experience a loss in lean body mass (LBM). This decrease in LBM is usually accompanied by an increase in fat (adipose) tissue. Scientists also agree that the older individual is less active physically than in the early and middle adult years. Because fewer calories are used via physical exertion, it is assumed that the older person requires less caloric intake. In order to preserve lean body mass and optimal health, these calories must be of the highest nutritional quality. The question remains—what is the best combination of required daily allowances for the aged adult?

Age-related degenerative changes in body composition also include a loss of muscle mass (with concomitant loss in motor function) and a loss in bone tissue (resulting in fragile, easily fractured bones). Thus, we also need to know if this age-related decrease in muscle fiber can be prevented or stabilized by eating more foods with protein and amino acids and, if so, how much and how soon? Can osteoporosis, a brittleness of the bones especially problematic in older women, be avoided with calcium-rich diets and, if so, how much calcium is required?

As individuals grow old, the efficiency of their kidneys decreases. This raises several questions, such as: Can ingestion of high-quality protein and amino acid-containing foods moderate this change? Should we be looking at the role of fluid and sodium intake on a weakened renal (kidney) system?

It is well known that the elderly suffer from a number of gastrointestinal maladies, the most common one being constipation. In addition to studying the effects of high-fiber foods, we need further investigation to determine if there are other dietary adjustments which will alleviate these kinds of gastrointestinal disorders.

We know that the elderly person has experienced a lifetime of diseases and environmental assaults on his or her body, but we do not know how to plan a good diet during or in the aftermath of the acute and chronic illnesses common among the elderly.

Old age often necessitates major changes in lifestyle that adversely affect eating habits. The aged person often finds himself or herself poorer than he or she had been during the early and middle years. In addition, an elderly person is more apt to experience the death of a spouse or close friends than any other age group. The old frequently are less able to take care of themselves, largely due to degenerative physical changes. An aged individual may suddenly find that the neighborhood where he or she has enjoyed security for many years has become a high crime area. Finally, old people may suddenly find themselves the victims of age prejudice, or "ageism." Any of the above situations can cause sufficient emotional trauma (grief, loneliness, depression) so great that one loses the desire to eat. This loss of appetite, known as anorexia, combined with financial restrictions on food purchase and fear of going out to the store, makes it easy to understand why many old people are seriously undernourished.

As a first step toward implementing the recommendations made at the conference, the NIA recently issued a revised, expanded request for research grant applications, with emphasis on the following areas:

—Epidemiologic and clinical research on the relationship between aging, nutritional status, dietary intake, and health status;

—The effects of specific diseases on nutritional status and interactions of nutrients with therapeutic agents, surgical procedures, or preventive regimens;

—The effects of aging on nutrient requirements and utilization, digestion, absorption, and metabolism;

—Basic and clinical nutrition studies on the interrelationships between aging and: (1) Factors which may regulate changes in lean body mass, body composition, energy balance, regulation of metabolic processes, and disease susceptibility; (2) the effects of nutritional deficiencies on long-term health and longevity; and (3) the effects of nutrition on age-related mental changes.

The Older Woman

Are women really the weaker sex? If there is strength in numbers, they are not. Women in the 65-and-older age group are the fastest growing segment of the U.S. population, with 13.9 million older women (versus 9.5 million older men) in 1977, expected to increase to 33.4 million women (versus 22.4 million men) by the year 2035. Women are also living much longer than men, a gap in life expectancy which will continue to widen into the next century. This growth in the number of older women is having an enormous impact on society. Yet the needs and achievements of older women have largely been overlooked.

To explore a wide range of issues concerning the older woman and to identify areas in which research is needed, the NIA and the National Institute of Mental Health (NIMH) cosponsored a workshop on the older woman. From these discussions—and a diversity of research studies, backed by statistical and case material—emerged a portrait of the typical woman in her seventies and beyond. Her life is marked by the continuities of working in the home and of maintaining emotional connections with family, children, and peers. But her life is also marked by the discontinuities of an interrupted carrer and large numbers of losses—including the departure of children from the home, and the likelihood of outliving her husband. She is assailed by unflattering stereotypes and by poverty, poor access to transportation, loneliness, and isolation. She is three times as likely as her male peer to live in a nursing home. Her life seems precarious at times: there is the real possibility that she may become a patient and/or a pauper. Despite the litany of problems the older woman faces, she also possesses great strength and potential, as witnessed by her ability to survive.

Of considerable interest to this country's 31 million postmenopausal women and their doctors are the risks and benefits of estrogen administration. In a preliminary effort to organize the study of these risks and benefits, the NIA convened a group of experts to assess the suitability of holding a consensus meeting on estrogen use. Although some participants felt that the issues require so much more research that it is premature to attempt to reach consensus at this time, the prevailing view was to proceed in order to compile, evaluate, and effectively disseminate the information already available. Therefore, the NIA will sponsor a consensus exercise in the near future, with emphasis on the following topics: The benefits of estrogen use for the treatment of menopausal symptoms and for the prevention of osteoporosis and possibly heart disease; the hazards of estrogen use, particularly cancer; the relative risks and benefits of various forms, routes, doses, and schedules of estrogen therapy; and acceptable indications for and patterns of estrogen use.

In addition to NIA efforts to stimulate interest in the problems of older women among the scientific and academic communities, the recent inclusion of women in the Baltimore Longitudinal Study of Aging will provide Institute scientists with an opportunity to study the aging process in women firsthand, and perhaps shed some light on the differential life expectancy between the sexes and among various racial and ethnic groups. As of the fall of 1978, some 150 women have been introduced into the study.

Geriatric medicine

The NIA's continuing interest in facilitating the teaching of geriatric medicine as a part of basic medical training gained momentum during 1978 with several key developments. The NIA contracted with the Institute of Medicine (IOM) of the National Academy of Sciences to examine how best to incorporate geriatric medicine into medical school curriculum. The IOM report noted that current medical training in the care of the elderly is deficient, but the committee recommended against establishing a separate specialty or subspecialty of geriatrics, instead suggesting the creation of sections on geriatric medicine within departments of internal medicine. By encouraging the inclusion of geriatric medicine in the mainstream of medical practice, the report avoids possible arguments on the necessity of still another specialty and prevents the further isolation of the elderly from the mainstream of American medicine.

The American Medical Student Association has shown a great deal of interest in geriatric medicine, most recently devoting an entire morning session to the subject at its annual meeting in March 1978. Two months later, the Association of Professors of Medicine considered geriatrics at its annual meeting. The Director of the NIA participated in both discussions. In September 1978, the board of governors of the American College of Physicians heard a presentation by the NIA Director on geriatric medicine.

In the spring of 1978, Dr. Milo D. Leavitt, then director of the Fogarty International Center (FIC), spent 6 weeks in the United Kingdom visiting 8 out of the 10 British medical schools with chairs in geriatric medicine and studying the educational, research, and service aspects of geriatric medicine in that country. Upon his return, Dr. Leavitt became the NIA Director's Special Assistant for Medical Program Development and Evaluation. In this role, he prepared a report which detailed the strengths and weaknesses of the British system, concluding that although the United Kingdom is ahead of the United States in its understanding of aging, a direct transplantation of their practice of geriatric medicine to this country would probably not be appropriate.

The NIA's nomination of Sir Ferguson Anderson, one of the world's foremost geriatricians, to be a Fogarty International Scholar was accepted. He plans to begin his year here in September 1979, participating in a variety of activities designed to speed the transmission of knowledge regarding geriatric medicine to American medical school students and faculty, as well as policymakers and scientists in the field of aging.

Funds for training in geriatric medicine have been provided to the FIC senior international fellowship program (also known as the Magnuson fellowship) and the Bureau of Health Manpower of the Health Resources Administration. The NIA will coordinate with these agencies on both efforts.

Finally, the NIA recently initiated a Geriatric Medicine Academic Award to provide a stimulus for the development of a curriculum in geriatric medicine in those schools that do not have one and to strengthen and improve the curriculum in those schools that do. At the same time, a Clinical Investigator Award was announced, which would provide an opportunity for promising clinically trained individuals to develop research ability in preparation for independent research careers. Post doctoral training opportunities in both clinical and basic research continue to be available at the NIA Gerontology Research Center.

Longevous Populations

Since the beginning of time, man has searched for the key to perpetual life. Reports of groups of people living past 100 in certain parts of the world have sparked the imagination and conjured up dreams of Shangri-la. At a meeting sponsored by the NIA and the FIC, Dr. Richard Mazess, of the University of Wisconsin, at Madison and Dr. Sylvia H. Forman, of the University of California at Berkeley, disclosed that those persons thought to be centenarians in Vilcabamba, Ecuador, are not. In cooperation with Ecuadorian scientists, Drs. Mazess and Forman investigated civil and church records and found that the oldest living villager was 96. Much of the confusion stems from the custom of passing a family name from one generation to the next. Because of this tradition, the actual recorded birth dates of those persons living in Vilcabamba are frequently confused with those of their parents and grandparents. Another common practice is to give a surviving child the same name as that of a sibling who has died. Consequently, a person's "age" is often the sum total of more than one family member. The scientists also found that after the age of 60, many villagers begin to exaggerate their ages. Increased worldwide attention only exacerbated this phenomenon.

However, there is still much that can be learned by studying the people of Vilcabamba and other long-living populations. For one thing, the incidence of arteriosclerosis in Vilcabambans 80 and over is particularly low, whereas in the United States the number of deaths caused by this hardening of the arteries peaks at age 80. In addition, Dr. Mazess' work shows that there are fewer bone fractures in elderly Vilcabambans despite the loss of bone density that is common in old age in the United States.

Cellular and Animal Resources

Many aging research advances would not have been possible without the NIA's development of special resources for gerontology researchers. Currently, the NIA's basic aging program contracts with the Institute for Medical Research (IMR) in Camden, N. J., for two cell resource/services. The first is a cultured cell bank. Via this effort, NIA establishes, characterizes, stores, and distributes standard and genetically marked human cell lines for aging research. The second, more recent NIA–IMR resource is a mycoplasma contamination testing service which performs a vital function for researchers who use cells to study aging processes. Mycoplasma are tiny, evasive organisms, smaller than bacteria but larger than viruses, which frequently infect cell cultures. Mycoplasma can alter the characteristics and behavior of cultured cells so dramatically that their mere presence compromises research results. The mycoplasma testing facility enables researchers to spot check their cell cultures by periodically sending in samples for analysis. The testing facility focuses not only on mycoplasma detection but also on mycoplasma prevention and control.

Because practically every field of biomedical aging research depends heavily on the development and availability of appropriate laboratory animals as research models, several animal resources have been established by the biophysiology and pathobiology aging program of the NIA. Disease-free aged rodents are available to NIA scientists today because the selection processes and logistics necessary to establish these colonies began several years ago. In addition to providing the animals themselves, the NIA keeps scientific data on the animals' life spans, growth patterns, organ weights, age-associated diseases, and blood chemistries.

The NIA is working with the National Academy of Sciences (NAS) to determine which animals will prove to be the most relevant to future aging research investigations. The NAS is at work on a report which will assess selected vertebrate species for aging research. The NIA is also working with the Division of Research Resources, NIH, to survey existing colonies of aged laboratory animals for use by gerontology researchers.

Geriatric Dentistry

Currently, all three major programs of the NIA are involved in the conduct or initiation of work in geriatric dentistry. Approximately 6 months ago, NIA intramural scientists added a dental evaluation component to the already extensive physical and mental examination protocol used in the Baltimore Longitudinal Study of Aging. Dr. Bruce Baum at the Gerontology Research Center (GRC) developed the dental protocol, which includes clinical evaluation of gum diseases, cavities, changes in the senses of taste and smell, oral hygiene, salivary and related oral gland function, and alterations in denture-retaining ridges. Biochemical tests are also performed on saliva samples.

The NIA extramural and collaborative research program (ECRP) is coordinating with the National Institute of Dental Research to identify areas of overlapping interest and high priority with the eventual goal of funding meritorious research to explore the many aspects of geriatric dentistry. Topics of interest to both Institutes include: root cavities, gum disease, oral tissue changes, wound healing, immune capacity, elderly cleft palate, removable dental appliances, loss of teeth, oral bone loss, nutrition, oral cancer, denture sores salivary function, therapy compliance, oral hygiene, and taste and smell changes which accompany aging.

The epidemiology, demography, and biometry program (EDBP) of the NIA has taken steps to initiate the compilation of dental information from already existing surveys. With guidance and funding from the NIA, data from the health and nutrition examination survey (HANES) will be reexamined closely to collect important information on the older population. During the first planning year of this effort, the EDBP will recommend a special examination of the dental information originally collected by the HANES researchers. The EDBP also hopes to support a team of nutritionists, dental researchers, and epidemiologists to look at the relationship between dental problems and nutrition in the old.

Accidental Hypothermia

NIA information activities continue to alert the public, and particularly the elderly, to the danger of accidental hypothermia, a potentially fatal drop in deep body temperature that can result from prolonged exposure to even mildly cool temperatures. A press conference was held in December 1977 on this topic and a lay-oriented brochure was prepared which describes the condition, explains who is at risk, and tells the elderly how to protect against accidental hypothermia. The story received wide coverage in both national and local media, and led to the addition of a warning to the elderly in the Department of Energy's "Tips for Energy Savers" booklet. The brochure was widely distributed during the winter in supermarket information racks in States with cold winter climates. A similar broad distribution is underway this winter, supplemented by a national public service announcement warning the elderly and their families about accidental hypothermia and directing them to their supermarket information rack or to the NIA for further information. Requests for additional information have come in from State health departments and energy offices, and also from a variety of organizations concerned with the elderly.

RESEARCH ADVANCES

Osteoporosis and Vitamin K

The effects of osteoporosis, a degenerative weakening of the bone that leads to hip fractures in many elderly women, may be arrested with adequate vitamin K intake. Osteoporosis is believed to precipitate about 195,000 hip fractures annually, primarily among elderly women, and is a major cause of physical disability in old age.

Institute grantees have discovered that when an individual experiences a vitamin K deficiency, the resulting decrease in the protein osteocalcin causes calcium loss in bone. This calcium loss, in turn, causes a decrease in the amount and strength of bone tissue in old people, making affected bones weak, porous and highly susceptible to fracture.

Vitamin K, long recognized for its role in blood coagulation, is now believed to be vital to calcium "turnover" in bone. Among the evidence for this relationship is the fact that fetal bone deficits have been common in children whose mothers received drugs during their pregnancies that interrupted the metabolism of vitamin K.

By selecting foods which are "easy to digest," the elderly often exclude vitamin K-containing foods such as green vegetables, cauliflower, potatoes, and liver.

Older people frequently use mineral oil laxatives which coincidentally interfere with vitamin K absorption. They may also take drugs which cause metabolic inactivation of vitamin K. Finally, estrogen deficiency experienced by postmenopausal women often contributes to impaired vitamin K metabolism.

Continued research is expected to delineate further the relationship between vitamin K, calcium metabolism, and osteoporosis.

Calorie Counting Can Change Number of Fat Cells

The number of fat cells (adipocytes) in the body has long been believed to remain constant throughout adult life. An overabundance of food during the first years or so of a human's life, according to this theory, was likely to lead to a large number of fat cells in adulthood but the number, once established, has been thought to remain unchanged.

Now Institute-supported studies of rats show that the number of fat cells, rather than remaining constant throughout adult life, increases in the fatty tissue around the kidneys of these animals. Related studies show early that restriction of food intake lowers the size and number of adipocytes formed in the same tissues. This effect occurs not only during early life of rats, but at any point during adult and later life, a finding which may enhance the medical evaluation and management of obesity, a serious problem in old age.

Further work by the same grantees indicates that the adipocytes of animals whose caloric intake is restricted are significantly more responsive to certain hormones which release fat from fat cells and carry it to the blood, so that the body's tissues can convert it into energy. Food restriction appears to delay decline in this function which ordinarily accompanies aging.

The investigators also found that food restriction enhances an animal's ability to maintain muscle functioning and keep blood fat levels from increasing. Rats whose food was restricted maintained a more youthful appearance and behavior than was "normal" for their age group. These findings have important implications for the prevention and treatment of diabetes, and coronary heart disease.

Enhancing Wound Healing in the Aged

Serious physical injury in both humans and rats is associated with increased excretion of nitrogen in urine, which indicates an increase in protein loss from the body. In humans, the quantity of nitrogen lost may cause a negative nitrogen balance in the body that is believed to adversely affect wound healing. The extent of this nitrogen/protein loss is usually related to the severity of the trauma suffered, previous protein nutrition, cold or heat stress, sex, and age.

Thus, a major clinical problem for the aged is maintaining a positive protein (nitrogen) balance in order to enhance wound healing and reduce surgical and postsurgical risks. Conventional diet therapy programs following severe injury have been aimed at providing liberal amounts of protein and energy to the patient. Another approach is to minimize the excretion of nitrogen.

Institute grantees studying protein metabolism and stress in aged rats have reported that rats traumatized under ether anesthesia showed an increase in nitrogen excretion that was accompanied—and perhaps caused—by a trauma-associated decrease in the liver content of copper manganese and zinc. By increasing the intake of these minerals above the usually recommended dietary levels, the investigators were able to reduce nitrogen excretion. They also discovered that nitrogen loss could be reduced in traumatized animals by adding two amino acids, arginine and glycine, to their diets.

In addition, the grantees demonstrated that about 50 percent of the total nitrogen loss may be caused by either anesthesia alone. This suggests that in surgical procedures, the use of anesthesia should be considered sufficiently traumatic to be accounted for in planning the nutrition of the patient.

Important Developments in Cell Biology

For years, human cell culture science has profoundly affected many areas of biological research, including immunology and genetics. Observations of human cells are vital to the study of human aging as well, especially since hundreds of experiments, otherwise impossible to perform on man, can be carried out on live cells grown in the laboratory from small slivers of human skin and other tissues.

Cell biologists have long known that human cells grown in laboratory culture medium (in vitro) lose their ability to reproduce at a certain point, and that the younger the age of the cell donor, the greater the number of cell divisions in culture.

Recently Institute-supported researchers have made several important discoveries about the structure and function of live human cells grown in vitro. One discovery concerns the structure of WI-38 cells, a strain derived from female fetal lung tissue. For many years, this normal human cell line was the "line of choice" in cellular aging research because of its limited "life span" or ability to proliferate in culture.

Using a high voltage electron microscope, grantees at the University of Colorado have been able to observe three-dimensional detail of subsellular structure and have discovered that the WI-38 cell has a three-dimensional lattice structure. As part of the skeletal system of the cell, this structure helps determine the cell's shape, and may also be part of the mechanism whereby other structures move around within the cell. Having described this aspect of subcellular structure, researchers are now looking for age-associated changes in this structure.

In another significant development, grantees at the Massachusetts Institute of Technology have recently suggested that when normal skin cells lose their ability to proliferate in a culture medium, this may be a sign not of cell aging, but of cell differentiation. Thus, instead of continuously proliferating, these cells lose the capacity to divide as they perform new functions. This change, or differentiation, may be similar to a change this cell-type undergoes in the body.

This work suggests that investigators should consider that "differentiation" as well as "aging" may be the reason normal cells lose their capacity to divide in culture. It emphasizes the need to extend cellular aging research to other cell types, and to determine how cells in the normal body compare to cells grown in culture.

Old Animals Can Compensate for Nerve Cell Loss

The biological basis for learning and memory stems from the unique ability of brain cells to change their functioning according to repeated experiences. No other group of cells in the body other than nerve cells has this capability, known as functional plasticity.

Decline in memory and ability to learn in old age is a critical problem because the aged brain is highly susceptible to loss of nerve cells. Such losses are part of the normal aging process as well as a side effect of stroke, tumors, senile dementia, and similar disorders.

In recent studies comparing aged and young animals, Institute grantees have shown that old as well as young animals are able to compensate for never cell loss. As part of a system similar to a complex communications network, each nerve cell in the brain receives inputs from thousands of other nerve cells and each of these, in turn, forms connections with hundreds of other nerve cells. When one or more inputs to a nerve cell is destroyed, in some instances the remaining cells which still maintain "terminals" to a target cell form new connections compensating for those that were lost. This process, known as reactive synaptogenesis, has been well documented in the developing nervous system, but was not known to take place in the aged brain.

Now grantees have demonstrated that aged rats the equivalent of about 80 human years exhibit similar reactive synaptogenesis, or the ability to regrow new brain circuits. But the regrowth is much weaker than in younger animals and sometimes forms improper connections to existing brain cells, causing the animal to behave abnormally.

Why connections are made properly or improperly is still not known, although further studies will explore these mechanisms. The discovery that older nerve cells can compensate for cell loss could—if ways are found to enhance the proper type of regrowth—reduce the damage caused by senility, stroke, memory loss and other degenerative changes of old age.

How Smell and Taste Change with Age

To meet the often neglected nutritional needs of the elderly, it is necessary to learn how foods taste and smell to them, and how foods can be modified to enhance flavor. NIA-supported studies of young and elderly subjects revealed that the older group was considerably less able than the younger to identify, by taste and smell, a variety of foods and flavors including chocolate, grape, orange, lemon, cherry, tomato, cheddar cheese, bacon and mushroom. Reduced sensitivity to food odors, rather than lack of taste, appeared to be the main reason elderly subjects incorrectly identified these foods.

Other studies by the same investigator indicated that the continued use of smell—for example, by professional perfumers—over a person's life span may retard the decline of smell sensitivity and that stronger odor made food more flavorful to the elderly.

The investigator also suggested that one way to enhance food flavor might be to add certain amino acids with sweet or salty components to the diets of the elderly. This would make it possible to lower the undesirably high salt and sugar content of many elderly person's diets, and perhaps improve the protein intake without increasing saturated fats.

The diets of the elderly may improve with better understanding of how taste and smell of foods and nutrients are affected by normal aging and by age-related diseases, and of how food palatability can improve with salt and sugar substitutes and other taste- and flavor-enhancing substances.

New Method Allows Study of Permeability of Blood-Brain Barrier

Age-related changes in the central nervous systems of man and animals may be caused by breakdown of the blood-brain barrier, which restricts exchange of water-soluble drugs and proteins between the blood and brain.

Institute scientists at the GRC have developed a new way to measure permeability of the blood-brain bar rier in rats. This method, which is 1,000 times more sensitive than other tests currently available, allowed the researchers to demonstrate that blood vessels in the brain remain intact despite age-related brain changes in senescent rats.

This method also measures the rates at which certain drugs enter the brain, until now a problem because the blood-brain barrier made it impossible to measure the actual concentration of a given drug in the brain. Old people tend increasingly to react adversely to drugs that affect the central nervous system, although the same drugs normally are not toxic in younger individuals. It is not known, in some cases, whether changes in response to a drug are caused by increased entry and retention of the drug within the brain, or to altered brain sensitivity to a given concentration of a drug. It should now be possible to distinguish between these effects and to predict, based on the measured concentration of a drug in the blood, the actual concentration in the brain.

These investigators also developed a way to temporarily increase the permeability of the blood-brain barrier to drugs that normally cannot enter the brain. It is now possible to allow certain drugs and other substances that affect the central nervous system into the brain to study how they interact with brain cells in relation to central nervous system function, disease and aging.

Cardiovascular Disease and Intellectual Decline with Aging

While the debate continues over whether cognitive behavior and intelligence normally decline with advancing age, one Institute-supported longitudinal study has related cardiovascular disease to intellectual decline in middle-aged and older people. Cardiovascular disease has long been suspected of undermining cognitive function to the extent that it disrupts blood flow to the brain. Grantees followed a sample of subjects—an original 500 narrowed to 156 over time—and divided them into groups with or without cardiovascular disease based upon their health histories. Results showed that subjects with stroke or arteriosclerosis (hardening or the arteries) were the most likely to drop out of of the study, and that members of the groups that remained were more likely than those who left to show a greater drop over time in scores on tests measuring mental ability and speed of performance.

However, individuals with high blood pressure were not as likely to drop out of the study or to show a decline in intellectual performance on the various tests administered. This result confirms earlier work suggesting that mildly elevated blood pressure may help maintain intellectual functioning in old age.

The study does not explain how intellectual decline takes place, although reduced oxygen supply caused by decreased blood flow in the cerebrovascular system may impair the function of the nervous system, and the life style changes and social isolation that cardiovascular disease often enforces may adversely affect intellectual functioning.

By showing that changes in cognitive behavior vary according to the subgroup involved, this study alerts investigators to consider such individual differences in future attempts to predict how cognitive development changes with advancing age.

Relationship of Aluminum to Alzheimer's Disease

Alzheimer's disease is a poorly understood disorder of the brain cells in which groups of nerve endings in the outer layer of the brain degenerate and disrupt the passage of electrochemical signals between the cells. These area of degeneration have a characteristic appearance under the microscope, and are called plaques. The larger the number of areas of degeneration, the greater the disturbance in intellectual function and memory.

Until recently, Alzheimer's disease was believed to be rare, but new evidence demonstrates a high frequency: it is estimated to affect from 500,000 to 1.5 million Americans of all ages. The cause or causes of Alzheimer's disease remain unknown, although recent evidence points to several possibilities. Research by grantees at the University of Toronto shows that the brains of people dying of Alzheimer's disease contain high accumulations of aluminum. Other studies by these grantees in collaboration with scientists at the GRC suggest that the aluminum may interact with DNA, a substance found in all living cells that carries primary genetic information.

Early results indicate that this binding has dramatic effects on the structure of DNA molecules. Specifically, aluminium forms crosslinks between the DNA strands and—although further research is needed to verify the possibility—could be responsible for the lesions that characterize Alzheimer's disease. Further research is needed to verify this possibility and to explore the mechanisms by which aluminum affects DNA.

Baltimore Longitudinal Study of Aging Results

Two of the most life-threatening conditions in old age are cancer and infections diseases. The NIA's Baltimore Longitudinal Study of Aging has recently provided information about age-related changes in human immune function that may influence susceptibility to these conditions. Studies of participants in the Longitudinal Study have shown that the ability of certain immune cells (lymphocytes) to kill human tumor cells decreases markedly beginning in the fifth decade of life. Furthermore, those immune cells which fight acute infection (neutrophilis) now appear to become less efficient with advancing age. These and other research results permit a better understanding of immune function in both young and old persons, and may form the basis of improved diagnostic procedures for detecting immunodeficiencies.

Another study at GRC involves the effects of aging on motor behavior such as turning or walking. It is well known that some disorders associated with senescence may result from age-related changes in the activity of specialized receptors which control the body's ability to respond to specific hormones and other body hemials. GRC investigators have recently characterized these changes more specifically in studies of the rodent showing that aberrations in motor behavior may result from a failure of certain neurotransmitters, which carry nerve signals to receptors, to be released as effectively in the senescent animal as they are in the young. Motor behavior changes may also result from a loss of receptors upon which these neurohormones act during the transmission of nerve impulses within the motor areas of the rat's brain. These studies characterize, for the first time, a possible hormonal change in the central nervous system in relation to a very simple motor behavior in the aged rat.

Personality Characteristics of Men with Good Visual Memory

A study of 857 men between the ages of 30 and 80 in the Baltimore Longitudinal Study of Aging revealed that while visual memory of designs declines with age, particularly after age 70, it does not decline for everybody. In a sample of men measured for the first time when they were 70 and over, one in four showed no decline in visual memory performance when tested 6 years later. Another analysis of men measured initially during their 60's showed no decline 6 years later, but at 12 years showed a decline similar to that of the 70-year old group. The performance test consisted of reproducing geometric designs from memory after each design was displayed for 10 seconds and then withdrawn.

These researchers are also exploring why some individuals decline in memory performance and others do not. They are attempting to identify personality characteristics associated with changes in memory performance among men 70 and over. Initial results show that men who maintain memory performance have good emotional control, are energetic, and are oriented toward impersonal, analytic tasks. Individuals who decline in memory performance over time exhibit emotional instability, low energy levels, and less orientation toward tasks.

Calorie, Cholesterol and Fat Intake Decreases with Age in Longitudinal Study

Longitudinal research at the Institute's Gerontology Research Center has revealed that as a sample of 180 men in the study grew older, there was a decrease in their intake of fat and saturated fatty acid. Relative caloric intake also changed with age. For example, as age increased, fats contributed less to caloric intake and carbohydrates contributed more.

The study covered the period from 1961 to 1975, and included men ranging from 35 to 74 years of age at the beginning of the study. Analysis of their 7-day dietary diaries revealed that the ratio of polyunsaturated to saturated fatty acids increased an average of 26 percent during this time period when age was held constant, thus representing a change over time and not an effect of aging. Cholesterol intake decreased by 19 percent, from an average of 587 milligrams per day during the period 1961–65, to 478 milligrams per day in the period 1971–75. It is not yet clear how these diet changes will affect the health of life spans of these men.

A related study covering the period 1963–76 showed a recent drop in the serum cholesterol levels among men aged 17 to 102 years, who are subjects in the longitudinal study. This finding confirmed evidence that cholesterol levels increase in young adults, level off in the middle years, and decrease in late adulthood. However, a striking drop of about 7 percent that was observed in all age groups in early 1970 cannot be explained either by changes in obesity or by men with high cholesterol dropping out because of death.

Although the diets of the subjects as a group did change over this time period (cholesterol intake decreased as noted above), the individual changes in cholesterol intake did not correlate with the individual serum cholesterol changes.

Exercise or other factors may have contributed to the change in cholesterol levels, and these variables will receive further study.

The Use of Psychological Tests in Predicting Death

Institute grantees have identified a number of behavioral measurements which are an important step toward being able to predict the deaths of a significant number of older adults within 2 years following testing.

Since the early 1960's, a growing body of research has shown that the psychological test performance of elderly people may be used to predict ensuing death. But tests thus far have often discounted the age of the subjects, have looked backward over a span of years rather than forward, and in most cases, have included institutionalized or ailing subjects.

The present study included 380 men and women who were healthy and capable of independent living, and took into account their age, which ranged from 60 to 89 years.

A wide variety of variables were assessed including demographic, cognitive, perceptual psychomotor, personality, health and social factors. Used in combination, 13 predictors seemed indicative of ensuing death. These included a rating of how much vitality the subject displayed during a brief interview, three psychomotor tasks believed to measure brain and neural function, and two personality tests measuring depression and whether the subjects felt in control of themselves and their lives.

Such tests—which are brief, easy to administer by untrained personnel, and easy for subjects to take—are currently undergoing further validation. Once validated, they might prove a useful part of routine health assessments of elderly patients. They might also alert physicians—just as a high blood pressure measurement signals circulatory problems—to begin preventive and remedial efforts and to advise patients to adjust their lifestyles. These tests are not intended to be used as the sole index of impending death or medical status, but are a supplement to existing biomedical assessment techniques.

Antecedents of Health in Middle Age

In an NIA-supported longitudinal study designed to assess various manifestations of health throughout the lifespan, a sample of about 350 men and women who entered the study as infants or children were followed up at ages 30 to 50. Results showed that:

Health deteriorated slightly between the third and fourth decades and continued deteriorating into the fifth decade for the men, but not for the women.

Participants tended to assess their health as "good" despite their own reported complaints, experience with illness, and objective findings. Sixteen percent of the women, but none of the men, reported poor health at age 50.

The most consistent complaint about ill health among women throughout the middle years involved the reproductive system. In men, it involved the digestive system. In both sexes, complaints of acute illness diminished with age, while complaints of chronic conditions increased. Women complained about physical problems more often than men.

Paralleling these complaints, pathology in women was most frequently found in the reproductive system. In men—despite their complaints about digestion—the most common actual problem was hypertension. There was a gradual elevation of blood pressure in both sexes throughout life.

The health of men appeared to be related to their education and to that of their fathers. Women's health reflected the education of their fathers and their husbands. Overall, a calm, self-controlled, and responsible personality, manifesting itself as early as 11 to 13 years, was found to be conducive to good health in adulthood.

Institutional Adaptation of the Aged

At every phase of life, people strive to control their environments. Old age, illness, and insufficient finances may cause a decline in control. This decline becomes even more pronounced in old people who must enter nursing homes and succumb to an institutional environment that exerts almost total control over the individual. The degree to which a person adapts successfully to institutionalization, one institute grantee reports, depends upon his or her feelings about predictability and control. The greater the choice the individual feels he or she has and the more predictable the new environment, the less negative the effects of relocation tend to be. And, once there, individuals who view themselves as controlling their own fate adapt less well to a controlling institutional environment than people who perceive themselves ruled by the world around them.

Personal control, or the ability to manipulate some aspect of the environment, can be exercised by involving the individual in arranging for admission to the nursing home.

Feelings of predictability depend upon the amount of preparation individuals receive before the move to a nursing home. They can be prepared for a new environment through educational programs, visits to the facility, or personal counseling.

Those patients who felt more in control over the move to a nursing home showed increased activity levels afterward, and reported they felt better emotionally and physically. Nurses' ratings of the group exerting more control showed these individuals to be healthier and to have a greater "zest" for life.

Although only 5 percent of the population over the age 65 is in nursing homes, this still represents about 1 million older people, each of whom might be aided by such tools for adapting to the stressful experience of institutionalization.

Other Findings From Aging Research

Aging research spans a wide range of disciplines, from cellular biology to the social sciences. From some of these areas, Institute-supported researchers reported that:

A system has recently been devised that measures the quantity of insulin-like hormones (somatomedins) in the blood serum of animals of various ages. This makes it possible to study how somatomedins and insulin interrelate in maturity-onset diabetes, and how the levels of other hormones change during aging.

Loss of the heart's ability to contract is a major cardiovascular problem for the aging. Grantees have discovered that increased levels of calcium between the cells can compensate for this loss of ability to contract. Their findings suggest that drugs which help calcium to enter the heart may alleviate this condition in the elderly.

In a study of kidney function in aging rats, grantees found that the activity of certain enzymes decreases with age. This resulted in decreased efficiency of the metabolic machinery in the kidneys of aged rats. Under stressful conditions like starvation or acidosis, kidney failure occurred.

Recent studies provide further evidence that a decline in thymus hormone secretion may play an important role in the age-related impairment of the body's immune system. This system enables the body to protect itself against foreign substances such as viruses, and against various diseases. Institute grantees have discovered that removal of the thymus—a gland at the base of the neck that is key in the immune system—accelerates age-associated changes in immune function. The grantee also reported that when spleen calls from old animals are transferred to young mice with intact thymus glands, the spleen cells regain their former immune function. This suggests that the thymus gland or its products may reverse or improve the immune deficiencies that accompany aging.

Regular exercise results in an increase in lean body mass, improved heart and lung function, better oxygen uptake from the blood into the heart and skeletal muscle, and increased glucose tolerance. Studies of exercised animals have clarified the biochemical changes responsible for these physiological improvements, and have provided a scientific basis for the intelligent use of exercise as a tool in preventive and curative medicine.

A behavioral study of migration patterns of the elderly population, compared to the general population, reveals that the elderly are more likely than the general population to move between, rather than within, States. Elderly movers are also more likely to live in the same household with one of their children, and to rent rather than own their dwellings.

A project which compares contemporary families with a large nationwide sample for 1880 and 1900 shows that older southern whites at the turn of the century were more likely to live in extended families, while southern blacks were much more likely to live apart from kin. At present, the tendency appears to be for older whites to live near, rather than with, their children, while older blacks are more likely to live with their children.

A model has been developed that relates age, race, and sex to deaths from five chronic diseases which account for 64 percent of all deaths: Heart disease, stroke, arteriosclerosis, hypertension, and cancer. Already the model has demonstrated consistent race differences in circulatory diseases. An early increase in black mortality appears, for example, to be related to a lower resistance of blacks to circulatory problems and risks. In addition, the model has delineated for each of these individual causes of death the "crossover" phenomenon in which blacks shift, at about age 75, from a disadvantage to an advantage over whites in terms of life expectancy.

Such modeling is a fast, cost-effective way to look at age-related diseases in a population, and to relate mortality data to other epidemiological studies. The model may also help researchers predict the physiological makeup of the older population, assess the impact of health programs over time, and understand how social, economic, medical, and other factors affect aging and mortality.

NATIONAL INSTITUTE OF ARTHRITIS, METABOLISM, AND DIGESTIVE DISEASES

Summary of Activities Related to Aging—1978

Among its various responsibilities, the National Institute of Arthritis, Metabolism, and Digestive Diseases is also concerned with the conduct and support of research into a wide range of important chronic and disabling diseases of the aging population. Many of these are associated with significant morbidity, disability, and high mortality. There are, in particular, several diseases under the purview of this Institute that occur most commonly in the aged and are of considerable concern because they limit activity, increase dependence on others, often require hospitalization, and can cripple. Diseases such as osteoarthritis, osteoporosis, benign prostatic hyperplasia, and maturity-onset diabetes afflict many aged people and constitute health problems of great social and economic importance. Of the various conditions afflicting the aging or aged, these are of special interest to the NIAMDD.

OSTEOARTHRITIS

About 31 million Americans have arthritis; the majority have degenerative osteoarthritis which is characterized by cartilage degeneration and bony overgrowth in joints. The severity of the disease varies from relatively mild to so serious that the patient is totally bedridden. In its report of 1976, the National Arthritis Commission made some specific recommendations for research. The NIAMMD is in the process of carrying these out in a phased approach and within the limits of available resources. The major research efforts center around the use of biochemical and bioengineering methods to advance fundamental understanding of the chemical, physiologic, and structural alterations that occur in the joints with aging, and the development of improved and longer-wearing artificial joints to replace those destroyed by disease.

Studies using animals with partial meniscectomy (an animal model for osteoarthritis in which the cartilage covering the two opposing bone ends in a joint has been partially removed) and other models that simulate the human disease model have proven helpful in further understanding the components of the osteoarthritis process and in evaluating therapeutic agents.

Two biochemical defects have been identified as bases for the inability of certain joint cartilage substances (proteoglycans) to cluster together or aggregate normally in osteoarthritis. In some cases the proteoglycans are unable to interact normally with a defective substrate while in other cases, the aggregation defect appears to arise from the proteoglycans themselves. Separate studies have shown that the breakdown of proteoglycan complexes and collagen fibers, a major supportive protein, in human joint cartilage may be attributed, at least in part, to enzymes which digest protein. Collagen is digested by a specific enzyme—collagenase—and the proteoglycans may be digested by cathepsin D. It does not appear that cathepsin D can act outside cell organelles or beyond the cell surface itself because of its biochemical requirements (a low optimum pH). Evidence has been presented however, for the presence of a group of other protein digesting enzymes of low molecular weight that diffuse through the matrix and digest proteoglycans at neutral pH. The active material from human cartilage has been purified and is activated by cobalt, zinc, and iron. Institute supported studies have been reported in which the enzyme collagenase and an inhibitor of collagenase were found in osteoarthritic cartilage. The findings suggest that breakdown in the osteoarthritic joint to the base bone occurs as a result of locally produced collagenase. This and other work on the histology and chemical response of cartilage to enzymes is serving to help understand progression of degenerative joint disease.

Perhaps the most exciting development in research of interest to those with osteoarthritis in the past 2 decades has been the evolution of the artificial hip joint. Hip joint replacement today is one of the most successful orthopedic procedures for restoring mobility to patients, even in cases where previous reconstructive surgery has failed. An estimated 80,000 total hip replacements were performed in the United States from May 1977 to May 1978. The artificial knee, the second most frequently replaced joint, is not yet as successful as total hip replacement. NIAMDD is currently increasing its support of investigations into the kinetics, biomechanics, and design and materials for various prostheses for knee and certain other joints.

The longer a hip prosthesis is in use, the more likely it is to wear out at the friction points ("material fatigue"); also, the likelihood increases of a loosening of the prosthesis at the points where it is attached with bone cement to the natural bone structures adjacent to the joint. NIAMDD is supporting research to determine the quantitative influence of variations in surgical techniques on the strength of attachment of the metal femoral head of the prosthetic hip replacement. It is still uncertain whether or not improvements in fixation can reduce fatigue fracture but attempts to improve attachment by cleaning the medullary cavity have been recommended. Greater improvement was obtained by thorough drying of the cavity than by either cleaning alone or the use of thin cement. Other studies have shown that thin rods and plates of vitalliumtype cast alloys have superior physical properties to stainless steel, while tensile yield strengths in this alloy excel the levels in all other current types of implants.

When moving parts come into contact, wear occurs. An NIAMDD grantee has devised a technique for analysis of wear particles in synovial fluid aspirates of normal and osteoarthritic joints. The nature and quality of wear particles within the synovial fluid specimen often correlate with the rate and mechanism of wear, as confirmed by examination of the joint implant or articular surfaces. This is a useful method of studying both wear rate and the biological response to wear in both arthroplastic and degenerative joints. It holds promise not only as a test for wear and toxicity, but also as a means to assist in the selection of materials and designs for improved articular implants.

In May 1978, a workshop was held devoted to the various aspects of mechanical failure in total joint replacement. Reasons for mechanical failure of artificial joints were explored—faulty design, loosening of cement, mechanics of use—and recommendation was made for a more systematic study of joint failures. The proceedings of the workshop, jointly sponsored by the NIAMDD and the research society of the American Academy of Orthopedic Surgeons, has been published and will be distributed to physicians, investigators and others concerned with improving the success of joint replacement.

As a result of the passage of the National Arthritis Act, the Institute is in the process of establishing multipurpose arthritis centers in various sections of the country. These centers consist of the facilities of a single institution, such as a medical school or medical center or a consortium of several institutions, where knowledge and staffs can be pooled, often in cooperation with the local community. The goal of these arthritis centers is to foster prompt and effective application of existing knowledge and to develop urgently needed new knowledge through a balance of research, education, and community-related activities. By the end of 1978, NIAMDD had awarded grants in support of 24 multipurpose arthritis centers. This program is expected to continue to grow in the immediate future consistent with the availability of high quality proposals.

OSTEOPOROSIS

This serious and complex bone-thinning condition is the subject of Institute research activity that is aimed primarily at the production of knowledge about bone formation, structure, and metabolism that can form the rational basis of new forms of therapy. With aging, bone resorption tends to be greater than new bone formation which can gradually lead to fractures, especially of the vertebrae. Although the process is more rapid in women than in men, after age 80 there is no sex difference in incidence of osteoporosis. The possibility that the formation of new bone might be stimulated by fluoride salts in the demineralized bones of patients with osteoporosis is being examined in a clinical study supported by the Institute. Other factors are also being studies for their ability to reconstitute osteoporotic bone.

In another aproach, utilizing the hypothesis that osteoporosis is caused by an increased long-term depletion of calcium from bone, a team of NIAMDD supported investigators has attempted to reverse this loss by improving calcium absorption through increased calcium intake, and found that calcium balance is improved as calcium intake increases. Two commonly used forms of treatment, estrogen/androgen therapy (supplying tissue-building sex hormones) and calcium supplementation, have both shown a decrease in age-related bone loss in patients suffering from osteoporosis although use of hormones may not be without risk of the patient. Investigations on the metabolism of bony tissues have also led to studies on the effects of prolonged bed rest in promoting the loss of calcium from the bones.

BENIGN PROSTATIC HYPERPLASIA (BPH)

Recent work has suggested that more than 40 percent of men at age 40 and 80 percent of men at age 80 have some degree of bladder outlet obstruction secondary to BPH or benign enlargement of the prostate gland and that as aging progresses, the incidence increases. Furthermore, it is estimated that more than 10 percent of these men will eventually require a major surgical procedure for correction. Untreated bladder outlet obstruction can result in urinary retention, infections, urinary stone formation and damage to the kidneys themselves, clearly a very troublesome condition quite prevalent among elderly men.

Institute supported research has recently produced findings that strengthen the belief that BPH is under hormonal control since this condition has now been shown to be associated with an abnormal local activity of potent androgens (male sex hormones). Prostatic hormone receptors are now being studies experimentally. In addition, it has been found that BPH can be produced in experimental animals by treating them with such hormones. The experimental animal models thus produced are being studies to help provide insight into what causes this disorder and how.

NATIONAL INSTITUTE OF MENTAL HEALTH

The National Institute of Mental Health (NIMH), as part of its overall goal of improving the mental health of the people of the United States, has had a special interest in the aging population because of their high vulnerability to disabling mental illness. During the later years of life, losses are usually suffered by aging individuals; including decreasing physical abilities, bereavement through death of spouse, and/or other important relatives and friends, retirement from lifelong occupations, and concomitantly a decrease in income and loss of meaningful roles. Each decrement causes emotional stress and may become a threat to the mental health of the aging individual.

In 1975, the estimated population of persons over 65 was over 22 million, or 10.5 percent of the total population, though at the same time the proportion of aging persons using mental health facilities was far below this percentage. In 1975, 4 percent of the admissions to community mental health centers (CMHC's) and 5.3 percent of the admissions to State and county mental hospitals were over 65. In addition, an estimated 76 percent of aging persons in nursing homes are considered mentally impaired, suicide rates are highest among persons over 55 years, and the incidence of mental illness among aged persons in the community has been estimated in various studies as between 10–25 percent. For this reason the aging should be considered a high-risk group for mental illness.

Because the mental health problems of the aging are so great, the NIMH established a Center for Studies of the Mental Health of the Aging (CSMHA) in 1975 which was to coordinate the Institute's research, training, and technical assistance efforts as they relate to aging and mental health. In 1977, the supplemental appropriation provided $2 million to be administered by CSMHA for the support of research grants and contracts. In fiscal year 1978, the total expenditure of NIMH for research in aging was $4 million and for training $2.4 million.

RESEARCH

The CSMHA carries the major funding for NIMH research in aging and also works within the Institute with related programs to carry out its mission of improving the mental health of aging persons. In general, the CSMHA research studies have a primary focus on mental health and illness implications of the aging process and of old age. The Center supports wideranging-multidisciplinary studies which include the following:

1. Etiology, diagnosis, course, and prevention of mental disorders in later life.
2. Treatment and the delivery of mental health services.
3. Program development, social policy, and social problems research in mental health and aging.

Several research projects funded in 1978 by NIMH follow. One study focused on learning whether it is possible for elderly persons to better their cognitive capacities and social functions through various methods of training. This research has great significance in the possibility that its methods may improve the cognitive function of aging persons.

Another project is developing information about the day-by-day mental and physical health concerns and practices of older persons. Data collected will include detailed information about health practices and its results could provide information about how to develop educational programs which could support efforts of older persons and their families to prevent breakdowns and institutionalization.

One research project is looking at the adaptive strategies of older persons who relocate their homes in other communities far distant from their roots. Individual characteristics which may determine different types of adaptation and environmental and situational factors which enhance an adaptative behavior will be explored. Data may be generated which will indicate how adaptive capacities of older persons could be enhanced.

Another study is exploring the incidence of indirect suicidal behavior among elderly chronically ill in hospitals and nursing homes. Examples of such behavior are noncompliance with medical recommendations, overeating, smoking, et cetera. This study may show how to prevent premature deaths whether immediate or over extended time.

TRAINING

The growth of the population group over 65 years of age, the high proportion of aged persons with mental health problems, both in the community and in institutions, and the limited number of clinical personnel now available who have expertise in caring for aging persons with mental health problems make clinical training a high priority. All training review committees in the Division of Manpower and Traning of NIMH support programs to train personnel to work with the mental health problems of aging persons. The CSMHA has focused on the development of new models for clinical services training and has particular interest in the following:

1. Basic education and mental health models: Model programs to provide specialty training to mental health professionals for work with the elderly.

2. Continuing education models:

(*a*) Training for qualified mental health professionals such as psychiatrists, psychologists, social workers, and nurses for specific knowledge and skills in working with the mental health problems of older persons. Particular consideration is given to in-service training projects for all levels of staff in community mental health centers.

(*b*) Projects to produce short-term training for community-based health care providers and other professional personnel who deal with aging persons who have mental health problems. Such personnel would not be in the mental health system.

(*c*) Model projects to provide short-term training for community persons within formal systems such as senior citizen center directors and informal support systems as self-health groups.

3. Special projects: These involve the conduct of conferences, seminars, and workshops to promote the identification and analysis of critical service needs and related training strategies in the area of aging and mental health.

In 1978, CSMHA funded four training projects in geriatric psychiatry at the University of Pittsburgh, University of Texas, Illionis State Psychiatric Institute, and Duke University. This has considerably expanded the number of psychiatrists who will be available for training others to work with aging persons with mental health problems.

TECHNICAL ASSISTANCE AND DISSEMINATION

The CSMHA provides technical assistance through consultation for the development and stimulation of research and training applications focused on the mental health of aging persons. Researchers and directors of training programs are encouraged to contact the center for discussion of ideas for new research or training projects. Concept papers, preliminary proposals and later drafts can be submitted for staff review and comment prior to formal submission of the proposal.

Major technical assistance efforts are available to public and private agencies at regional, State, and local levels with the objective of improving programs affecting the mental health of aging persons and especially the delivery of services to aged persons by community mental health centers. For this latter effort, CSMHA staff works with regional offices, States, and individual community mental health centers.

Technical assistance is carried out through consultation, active participation at national, regional, and local meetings and conferences, and development and distribution of publications and other written materials. Particular emphasis is placed on dissemination of information about NIMH funded research and training projects concerning the mental health of the aged.

The Institute had in process during 1978 the following publications which should be printed in fiscal year 1979:

1. Proceedings of the NIMH conferences on goals for research, training, and services.

2. A science monograph reflecting "new views on older lives" which examines some of the applications of the NIMH research for the mental health of aging persons.

3. "Rape and Older Women," a guide to prevention and protection.

4. A publication developed from the final report of a research project focused on social and medical services in housing for the aged.

CSMHA is in process of developing a consumer's report on long-term care and a volume on models of community mental health center's service delivery to the aged. An addendum is also being done to update reports on research on aging from 1976.

CSMHA plans in fiscal year 1979 to reprint four publications which have been much in demand. These are: a staff manual on mental health problems of aged patients in long-term care facilities, a social work guide for nursing homes, maintenance of family ties of patients in long-term care facilities and summaries of research supported by NIMH—1960 to 1976.

As the focal point for activities on mental health of the aging at the National Institute of Mental Health, CSMHA responds to inquiries from professionals and public alike and provides information and referral to other appropriate organizations when indicated.

Collaborative activities with National Institute on Aging, Administration on Aging, and other Government agencies.—Staff of the CSMHA serves on inter- and intra-agency committees which focus on long-term care, native Americans, community support systems, retirement, and rural mental health.

Administration on Aging/NIMH.—Held in fiscal year 1978 a joint conference on coordination of services of area agencies on aging and community mental health. This conference was one of the results of the interagency agreement between AOA and NIMH signed in fiscal year 1977.

National Institute on Aging.—A considerable array of formal and informal relationships exist between the NIMH Center for Studies of the Mental Health of the Aging and the National Institute on Aging.

In 1977 NIMH, through CSMHA, collaborated with the National Institute on Aging and the National Institute of Neurological and Communicative Diseases and Stroke in the planning and support of an international conference on the biology of Alzheimer's diseases/senile dementia.

In 1978 NIMH, through CSMHA, took the lead and collaborated with the two other institutes on a conference on the clinical aspects of Alzheimer's disease and senile dementia. The aim of this conference was to consolidate what is known about the nosology, diagnosis, and behavioral correlates of senile dementia and Alzheimer's disease; to review the efficacy, safety, and reliability of treatment and mangement modalities currently in use; to examine service delivery systems, including both formal and informal support networks; to underline research problems and challenges in the study of the late-life dementias; and to highlight promising new research directions.

OFFICE OF EDUCATION

1978 ACTIVITIES AFFECTING THE AGING

The Office of Education/Administration on Aging Interagency Committee on Aging (OE/OAO), organized in 1977, met monthly during 1978 for the purpose of gathering information and exploring possible resources to meet the goals and carry out the strategies of the OE/OAO 1976 joint working agreement. The need to provide opportunities for older persons to serve was considered along with the need to maximize educational opportunities for older persons through better use of resources of both agencies. Among the areas covered were: involving older persons as volunteers and using them as resources, especially in the performing arts and in the hospice movement; age discrimination; advocacy programs for the aging; the use of senior centers as learning or educational delivery centers and of community schools as sites for courses for older people.

The committee has established working relationships with a number of national organizations including the National Council on Aging, the National Center for Voluntary Action, the National Volunteer Organization for Independent Living for the Aging, the Institute of Senior Citizens, the American Association of Community and Junior Colleges, and Future Homemakers of America.

Information continues to come in from States and local agencies that agreements continue to be made and strengthened.

In place of a first annual report, the committee submitted a memorandum of needed action which covered findings on mutual interests of the two agencies and joint actions that could be taken once the committee's mission, goals, responsibility, and authority are established in both agencies. Among these are:

1. Supporting research, to obtain data on the education and learning needs of older adults, building on such data as the adult performance level study and the life skills project.

2. Supporting the continued operation of the interagency panel on research and development on adulthood which brings together some 25 agencies to identify and analyze ongoing research on adulthood to avoid duplication of effort and to fill gaps in information.

3. Building on assessments made by the States under the Vocational Education Amendments of 1976 on the needs of displaced homemakers by obtaining nationwide data on current and projected career opportunities for older displaced homemakers and the corresponding job and education developments that have taken place.

4. Developing a cadre of education and learning associates as a way of expanding the number of quality of trained personnel serving older adults in senior centers, nutrition centers, senior residences, nursing homes, and in home-based education programs.

5. Encouraging the growing emphasis on intergeneration activity in schools, community groups, and youth organizations by supporting study of those activities and by disseminating information on model projects. Such intergenerational activities include national school volunteers programs in which several million older persons are working with children and youth in elementary and secondary schools, as well as Vocational Education Act for consumer and homemaking education activities which prepare youth for involvement in nutrition, homemaking, and recreation programs for older adults.

In 1978, the Bureau of Occupational and Adult Education program strategies to increase educational services for older persons included:

1. Preparing older persons for employment and volunteer services in home economics through a State grant programs.

2. Encouraging the use of older persons as teacher aides in CETA-funded positions.

3. Continuing concern for older adults in urban guidance center planning.

4. Continuing recommendations to the State directors of adult education that special consideration be given to assessing the educational needs of older citizens, to designing delivery systems for their counseling and instruction, and to developing curricula to provide competency-based adult education for older cities.

BOAE is now developing a pilot program in cooperation with one State to use one or more senior centers and staff from an institution of higher education for expanding the delivery system for educational programs for older adults.

ADULT EDUCATION

The adult education program authorized under the "Adult Education Act of 1966," as amended, provides undereducated adults (persons 16 years of age and older) and opportunity to acquire basic skills necessary to function in society, to continue their education to at least the level of completion of secondary school and makes available the means to secure training that will enable them to become more employable, productive, and responsible citizens.

The program is a State operation administered by State education agencies according to State plans submitted to the U.S. Office of Education and approved by the U.S. Commissioner. States are allocated grants to pay the Federal share of the cost of establishing or expanding adult education programs in local educational agencies and private nonprofit agencies. The matching requirement for the State grant program is 90 percent Federal funds and 10 percent State and/or local funds.

The regulation of the adult education State grant program requires an annual review of priorities in the field in order to examine and update currently established priorities, identify new areas of national concern, and recommend new priorities for programs of national significance. For fiscal years 1977 and 1978, the following priority statement was distributed to the States for their guidance:

Involvement of Older Citizens in Adult Education.—The Congress, the National

Advisory Council on Adult Education, and other interested persons and groups have recommended to us (Office of Education) that we find ways of improving educational opportunities for adults who are 45 years of age or older. The adult performance level study also confirms that many older persons have a critical need for acquiring functional competencies and life coping skills. Of those persons who ranked in the lowest APL competency level, the study's findings show the largest percentage of persons in the age group of 60–65, followed by the age group of 50–59.

In response to this need, special consideration is being given to assessing the educational needs of older citizens, to designing delivery systems for counseling and instruction, to developing curricula to provide competency-based adult education for older citizens, and to evaluating the effectiveness and impact of programs for the elderly. We are moving to utilize established community facilities and programs to involve older persons in adult education through cooperative efforts with community agencies and voluntary groups that serve the elderly, such as: senior centers, nutrition programs, nursing homes, homemaker-health aid, and other home-based services.

Reports from the States indicated the following age distribution of participants is expected to increase in 1978.

	Estimate	Percentage
Age group:		
16 to 44	1,409,516	83
45 to 64	23,283	14
65 and over	45,477	3

Public Law 93–29 amended the Adult Education Act by authorizing the Commissioner to make grants to State and local educational agencies or other public or private nonprofit agencies for programs to further the purpose of this act by providing educational programs for elderly persons whose ability to speak and read the English language is limited and who live in an area with a culture different than their own. Such programs shall be designed to equip such elderly persons to deal successfully with the practical problems in their everyday life, including the making of purchases, meeting their transportation and housing needs, and complying with governmental requirements such as those for obtaining citizenship, public assistance, and social security benefits, and housing. However, to date no appropriations have been requested or made to implement this section.

PUBLIC LIBRARY SERVICES TO OLDER AMERICANS

Library and information services for the aging are supported by the Office of Education (OE) through projects funded under the Library Services and Construction Act (LSCA). In fiscal year 1978, public library projects increasingly directed their attention toward making educational, informational, and recreational materials and activities widely available to senior citizens living independently or in institutional settings.

Since the elderly reader represents one of the highest user groups of public libraries—according to a 1973 LSCA-supported national study—and aging is a special project area designated in LSCA program guidelines, public libraries are actively and creatively serving this vital, growing, and often neglected segment of the population.

An awareness of the types of services and materials desired by older persons is steadily increasing in the library field. The U.S. Office of Education has also disseminated a sourcebook which contains examples of many successful library programs in operation across the country. Among the programs described in "Library Programs Worth Knowing About" are some excellent examples of special projects for the aging which hopefully will act as a stimulus to the initiation and further development of similar projects.

OE has also applied itself to furthering cooperative ties with other Federal agencies in order to strengthen the services provided for senior citizens. As a result of the Office of Education and Administration on Aging joint agreement signed on December 23, 1976, some State library agencies and local public libraries established cooperative activities among existing State and community agencies for the benefit of older persons.

In many areas, libraries are providing information and sponsoring educational conferences dealing with the process of aging, its psychological impact, and the changing needs of older persons. Directed toward professionals and laymen working with elderly persons, such activities foster greater cooperation among agencies concerned with senior citizens and contribute substantially to the achievement of a positive attitude toward the aged in the community.

Working with and through other Federal, State, and local programs operating in the community, public libraries can also expand and enhance the total array of services being offered to the older adult.

The Fort Collins Public Library in Colorado, for example, cooperates with the retired senior volunteer program (RSVP) to utilize the time and talents of the elderly for mutual benefit. The library serves as a work station for volunteers participating in RSVP whose desires and skills match library needs. The volunteers work on a regular basis in different phases of the library's programs, ranging from involvement in the planning process of programs specifically aimed at the over-60 age group to participation on library boards and advisory councils to direct work in the library as aides.

In Oklahoma City, Okla., the public library and the American Association of Retired Persons (AARP) have cooperated to provide tax aid to senior citizens. Volunteers, trained by AARP in special tax areas that apply to older citizens and retired people, are located at various branch libraries several days each week to provide service on a drop-in basis.

Other examples of cooperative activities that provide consolidated services to senior citizens at one readily accessible site include the numerous programs public libraries sponsor at local nutrition centers. Supported by Federal funds from the Administration on Aging, these nutrition centers provide hot meals and a gathering place for lonely aged persons to eat. Libraries contribute to these meal-time get-togethers by presenting education and entertainment through books, audiovisual programs, discussions, et cetera. For example, the Bossier Parish Library, Louisiana, prepares semimonthly presentations for the participants of the hot lunch program. Past programs have included guest speakers and demonstrations and focused on topics such as money-saving tips, the making of terrariums and dish gardens, small gardening, et cetera.

"Lunchtime Theater," a program of the Springfield Public Library in New Jersey, is aimed at the more independent senior citizen and invites community residents to bring a bag lunch and enjoy coffee and travel films provided by the library.

Other lunch-time forums produced by libraries have included special programs for and about woman, in particular the older, widowed woman faced with a new lifestyle and an array of new decisions to make in all aspects of her life.

Public libraries have also provided the forum for National Endowment for the Humanities' programs that delve into social issues of special concern to elderly citizens.

In addition to such planned programs as speakers, films, and preretirement counseling, public libraries are also recognizing the importance of providing a congenial social atmosphere for older adults to gather and socialize. Many libraries fill the need for nonprogramed socialization for lonesome elderly people by simply offering a convenient central place where they can meet. Library "drop-in" centers in Massachusetts and the "stop-in" rooms in New Jersey libraries are good examples of the public libraries' interest in the well-being of its older clientele. These libraries offer older adults a place and the means for them to provide entertainment for each other, a place where common interests can be shared, informal conversation, hot drinks, and occasionally a volunteer to help write letters or solve a problem.

Although group activities and the companionship they provide have a significant role to play in the older person's life, the library can also assist the older adult with many highly personalized needs. Providing the individualized special information an older person requires is a library responsibility that takes many forms. Lending and reference services, along with immediate information and referral (I. & R.) services connect the elderly with front-line community agencies and governmental programs, for example, social security, medicare, medicaid, veterans' programs, et cetera, that provide for their well-being. I. & R. services in general, and those specifically designed for the aging population, are rapidly increasing in number. Cognizant of the elderly's special information needs, libraries are developing innovation I. & R. services such as the OASIS—older American special information services—program in California in which public libraries used LSCA funds to implement an I. & R. service delivered to rural areas from a roving van. The van is equipped with communications devices which provide contact with the main library for additional resources, and is staffed with personnel knowledgeable about community agencies, in particular those organizations concerned with the senior citizen.

Delving into a more specialized component of I. & R. services, the Medford Public Library, Massachusetts, has compiled a job bank for senior citizens. In making this service available, the library acts as a clearing house, matching senior citizens who apply with appropriate part-time work opportunities called in to the library by local merchants, businessmen, and individuals.

Providing information in another accessible format is the Bourne Public Library, Massachusetts, which publishes a monthly newsletter for the town's senior citizens containing information on local events of interest, job market possibilities, and other community news bits.

Since the interests and educational background of senior citizens are as varied as that of other cross-sections of the population, ranging from illiterate to highly skilled, libraries offer learning opportunities in a large number of ways. Adult basic education, including literacy instruction, taught in groups or on a one-to-one basis, reaches many older persons who need these important skills to make their retirement years more satisfying, enable them to cope with life's demands and become less dependent on others. For the increasing number of elderly citizens pursuing a lifelong learning pattern, library-centered independent learning programs offer a broad range of interests and are geared to individual study goals. For instance, retired and senior citizens are taking advantage of cultural enrichment and continuing education offered by learn your way centers in New York, Brooklyn, an Queens Borough public libraries. By making appointments to confer with learning advisors, specially trained librarians who help patrons find information or special materials, these people can be put in touch with a wide range of resources and be given continuing assistance on whatever their current interests may be.

Learning and recreational interests can also be pursued by the older person by participating as an active member of the community in regular library programs. Special cultural events sponsored exclusively for senior citizens are also available, such as the symphony for seniors program in Louisiana. This program brings classical music—opera, symphony, and chamber music—performances to older persons in isolated rural areas. Some library programs are brought directly to retirement and senior citizen centers and, in some cases, the elderly are provided transportation to the library for special programs. Librarians and volunteers, often older adults themselves, make person-to-person visits to the homebound, residents of nursing homes, and the aged in State-supported institutions.

The approximately 5 percent of senior citizens who reside in institutions are also served by libraries. When library users are no longer able to come to the building, the library mails materials or, in many cases, arranges for staff or volunteers personally to bring the services to the person's bedside. Visits to bring large print reading matter to nursing homes are sometimes accompanied by special programs or film showings. One project in Wisconsin, called Bi-folkal Productions, produced packaged program resources for use with nursing home residents. These kits contained slides, tapes, scratch-and-sniff strips, shapes to feel, poems and songs and skits in large print, film suggestions, bibliographies, an instruction manual and lots of ideas—everything necessary to do a program with a group of older persons. These packages were designed to enhance the well-being of older adults by providing stimulating, creative programs which would demonstrate the persons' capacity for growth and aid in important life review. Librarians using these kits have simulated county fair days in the nursing home, reviving many happy memories of the past for the residents. Such use of audio-visual materials has been shown to be an effective way of reaching geriatric populations. Travel films, old-time radio shows, cassette recordings, et cetera, provided by the public library also bring pleasure to the elderly who have much leisure time.

In addition to audio-visual materials, special equipment is made available by libraries to facilitate reading opportunities for the blind and physically handicapped, a large percentage of whom are aged. LSCA and Library of Congress programs complement each other in serving the elderly handicapped with talking books, braille, and other special reading materials loaned through a network of 154 regional and subregional libraries for the blind and physically handicapped throughout the country. Those elderly persons disadvantaged both by physical handicaps and by a limited ability to speak English can also receive library service in the form of talking boks, large print materials, recordings and reading aids, all in their mother tongue.

Older Americans from all ethnic backgrounds are served with special bilingual programs and services that recognize their diverse needs. Outreach programs bring information, education, survival skills, cultural pride and communication capabilities within the reach of bilingual citizens. In one program in Texas, for example, the service included a Spanish-English large print card with the phone numbers of important community service organizations (police, fire, social security office, ambulance, etc.) distributed for free by the library that produced it. Another bilingual project, the "Asian Community Library," located in California, serves all members of its multi-ethnic population, but the bilingual books, magazines, films, et cetera, have special significance for the aged clients who strongly desire to maintain ties with their homelands and cultures.

Preserving the cultural heritage of ethnic groups and the history of geographical locals is another library activity in which the aging play a prominent role. The talents, memories, and insight of older persons are tapped by many library-sponsored history projects. In Indiana, one such program featured family history and was cooperatively funded with the arts council. Local libraries provided meeting space and resource materials for a 10-week course on writing family history. This course employed a qualified local writer and was open for free to persons over 60. An anthology of the participants' work is also being compiled for the library collection.

Focusing on oral history, the Canton Public Library, Mass. sponsored a project to develop 2 hours of edited oral history video tapes on the history of the town. An intergenerational effort, this project involved history students from the high school interviewing elderly Canton residents. An advisory committee consisting of elderly townspeople, young adults, teachers from the high school, and the historical society director, designed the format for the tapes and helped in the actual production. The project's aim was to: (a) begin the video/oral history of the town; (b) develop a pool of library staff and residents who are trained in video-tape production so that an ongoing program might result; (c) encourage and observe the results of interaction between the young adults and the elderly; and (d) assess the value of video as an ongoing programming feature for the elderly.

Serving persons of all generations often necessitates tailoring activities to better serve a particular age group. For example, public and State library outreach programs which send bookmobiles out to isolated rural areas and to poverty pockets in the city have been, in some cases, specially adapted for use by the aged population. In Pennsylvania, the bookmobile sent to county homes for the aged and nursing homes is equipped with a hydraulic lift to accommodate readers confined to wheel chairs. Approximately 60 to 70 persons per week attend programs consisting of music, book reviews, speakers, and other forms of entertainment.

Another library delivery system, books-by-mail, also has notable impact on elderly persons whose mailbox can connect them with free, prepaid mailings of selected readings, framed art prints, recordings, and so forth. Some libraries have made this popular service even more suitable for the elderly's needs by not only providing large print books, but also large print book selection catalogs.

These examples illustrate the basic goal and concept of public library service to older Americans—making library materials, services, and programs available in all usable formats and providing them in the most convenient ways for the elderly client. The public library has become an advocate as well as a service agency.

The 1973 amendments to the Older Americans Act included opportunities for strengthening library services to older adults through a new LSCA title IV, older readers services. With no funds for the new title, special services for the aging population continue to be provided from funding available from title I, library services of the Library Services and Construction Act.

INDIAN EDUCATION

The Indian education program is authorized by title IV of Public Law 92–318, as amended by Public Laws 93–380 and 95–561. Part C of title IV provides funds for special programs designed to improve educational opportunities for Indian adults. "Adult," as defined in the part C regulations, means any individual who has attained the age of 16. This includes elderly Indians.

Activities supported by part C are as follows:

(1) Planning, pilot, and demonstration projects which are designed to test and demonstrate the effectiveness of programs for improving employment and educational opportunities for adult Indians;

(2) The establishment and operation of programs which are designed to stimulate (a) the provision of basic literacy opportunities to all nonliterate Indian adults, and (b) the provision of opportunities to all Indian adults to qualify for a high school equivalency certificate in the shortest period of time feasible;

(3) Research and development programs to develop more innovative and effective techniques for achieving the literacy and high school equivalency goals;

(4) Basic surveys and evaluations thereof to define accurately the extent of the problems of illiteracy and lack of high school completion among Indians;

(5) The dissemination of information and materials relating to, and the evaluation of the effectiveness of, education programs which may offer educational opportunities to Indian adults;

(6) The development and establishment of educational services and programs specifically designed to improve educational opportunities for Indian adults;

(7) The dissemination of information concerning educational programs, services, and resources available to Indian adults, including evaluations thereof; and

(8) The evaluation of the effectiveness of federally assisted programs in which Indian adults may participate in achieving the purposes of such programs with respect to such adults.

Indian tribes, institutions, and organizations may apply to carry out the activities listed in paragraphs (1) through (8); State and local educational agencies may apply for all activities except those described in paragraph (6); and other public agencies and institutions may apply for those listed in paragraphs (7) and (8).

In fiscal year 1978, $4,410,000 was available for grants under part C. Grants were awarded for 56 projects in 25 States to serve an estimated 13,200 adult Indians. The largest grant—$300,000—went to National Indian Management Services, Inc., Philadelphia, Miss., to conduct a national survey of the educational needs of Indian adults. For fiscal year 1979, $5,930,000 is available for part C grants.

During 1978–79, the Office of Indian Education in its national adult education meeting has and will continue to make its grantees aware of its commitment to the elderly American Indians.

The Office of Indian Education is continuing to cooperate with the Office of Human Development Services, the Administration for Native Americans, the Indian Health Service, and the Administration for Public Services of the Department of Health, Education, and Welfare, and the Office of Environmental Affairs of the Department of Transportation in increasing the base of knowledge about educational opportunities for elderly American Indians and to focus the involvement of Indian tribes and Indian organizations in the decisionmaking processes on problems of elderly Indians.

COMMUNITY SERVICE AND CONTINUING EDUCATION (CSCE)

Title I(A) of the Higher Education Act of 1965 (Public Law 89–329) provides funds to States and institutions of higher education for three purposes: To strengthen community service programs of colleges and universities; to support the expansion of continuing education in colleges and universities; and to support planning for resource materials sharing. The CSCE program has been especially designed to meet the educational needs of adults who have been inadequately served by traditional educational programs in their communities.

The State grant portion (90 percent of appropriated funds under this title) of the program is administered in each State by an agency designated by the Governor, under a State plan approved by the U.S. Commissioner of Education. The State agency establishes priorities and approves and funds institutional proposals. One-third of the program expenditures must be provided by non-Federal sources. The State grant program has supported a number of projects designed to assist the older American. During 1978, more than 200,000 individual participants were involved in 95 projects (including multiproblem areas) in 38 States at a cost of approximately $1,750,000 in Federal funds. Activities supported included programs to meet educational needs of the aging, legal aid and housing assistance, and programs providing training for professional and paraprofessionals providing care and services to the elderly.

Special projects, authorized by section 106, permits the Commissioner to reserve 10 percent of the funds appropriated in order to support projects which are designed to seek solutions to regional and national problems brought about by technological change. Such special projects are limited to demonstration or experimental efforts. Projects must be based on a design for and the implementation of organized continuing education activity for adults.

In 1978, a renewal funding was awarded the Institute on Aging at Portland State University in Portland, Oreg. This award of $83,038 will continue work on a demonstration model to help solve work-related problems of middle-aged and older workers. The project will identify alternative work roles and leisure options, develop a curriculum, test and evaluate the processes, and then synthesize and diffuse the products nationwide.

Total appropriations for fiscal year 1978 were $18 million. Of this sum $1,800,000 was reserved by the Commissioner for special projects, with $15,850,000 distributed to the States and $350,000 utilized for technical assistance activities under section 111 of the act.

COMMUNITY EDUCATION PROGRAM

The community education program, authorized by title VIII of Public Law 95-561, or the Education Amendments of 1978, provides grants to State and local educational agencies and to nonprofit, public and private agencies in order to stimulate the development of community school centers which provide educational, cultural, recreational, and other related services in accordance with local interests, needs, and concerns. Additional awards are made to institutions of higher education to train persons who will plan and operate community education programs.

Federal and/or State grants made to local educational agencies are for the the purposes of paying the administrative costs of planning, establishing, expanding, and maintaining these community-oriented programs. None of the costs of the actual services, educational programs, or other activities is supported under this legislation.

In order for a local educational agency to receive a grant, the applicant must propose to meet eight minimum elements which are considered to compose any community school. One of those minimum elements is the potential of the community education program to serve all age groups in the community including the elderly. In the local educational agency category, 48 projects were funded in fiscal year 1977 and 45 were funded in 1978 at an average cost of $35,000 per project.

CONSUMERS' EDUCATION

The consumers' education program, authorized by title IV, section 407, of the Education Amendment of 1974 (Public Law 93-380) provides funds to stimulate in both school environments and community settings new approaches to consumers' education efforts through competitive contracts and grants. These awards are used for research, demonstration, pilot projects, training, and the development and dissemination of information on curricula. In addition, funds may be used to demonstrate, test, and evaluate these and other consumers' education activities.

Fiscal year 1978 was the third funding year for this program and the Office of Education continues its support for projects addressing the consumer needs of the elderly—61 grants in 31 States plus the District of Columbia were awarded to bring consumers' education to many diverse population groups—7 of those 61 programs dealt extensively with meeting the consumer needs of the elderly. Some of the activities were directed toward providing consumer education and consumer advocacy training to low-income older, blind, and disabled citizens; and providing statewide demonstration training workshops for professionals in consumer protection offices and offices of aging, professors in universities with continuing education programs, and for retired professionals who will be trained to teach their peers in a train-the-trainer model.

CAPTIONED FILMS AND TELEVISION

Under the Education of the Handicapped Act, part F (Public Law 91-230, as amended), films and television are captioned for the deaf. The program provides a free loan of service of captioned theatrical and education movies to groups of deaf individuals across the Nation. A considerable number of the people served by this program are over age 65. Of great importance is the extension of the film program to include captioned television. Captioned television programs may reach as many as 5 million hearing impaired individuals over the age of 65.

Public television captioning has taken two forms: "Open captions," which are visible to all viewers, and "closed captions" which are visible only on sets and stations with decoding devices. The open captioned rebroadcast of the ABC evening news which was begun in November 1971 is the most extensive of these programs. The Bureau of Education for the Handicapped has expended over $2 million since its inception on this program. The current funding level which includes the captioning cost of ZOOM, a children's program, and other special programs for the hearing impaired is $573,141.

Since 1973, the Bureau of Education for the Handicapped has developed, in conjunction with PBS, a closed system of captioning. This system will make it possible for hearing impaired persons to have a wide variety of captioned television programing that will not interfere with the normal viewing habits of the general public. The system has been approved by the FCC. Current efforts are directed to the development of the decoders for the home television set and the delivery of encoder equipment to place the captions into the system.

The deaf and hard-of-hearing population is estimated at 13.4 million. A large percentage of this population is made up of older Americans whose hearing has deteriorated with age. These individuals are a prime audience for captioned television.

RIGHT-TO-READ

The national reading improvement program is authorized under title VII of Public Law 93–380, as amended. The right-to-read effort currently provides for reading assistance and instruction for children, youths, and adults, as well as funds for State leadership and relies heavily on the use of older Americans as volunteers.

In fiscal year 1978, the right-to-read effort continued to fund the National Retired Teachers' Association's reading academy project. This project is designed to provide reading assistance and instruction to in-school as well as out-of-school youths and adults, utilizing volunteers as tutors.

The right-to-read effort has a memorandum of understanding with the older Americans volunteer programs, ACTION. The purpose of this memorandum of understanding is to indicate the intent of the right-to-read effort and the Office of Older Americans volunteer programs to work cooperatively in improving the delivery of reading assistance and instruction through maximum involvement of older American volunteers in reading and literacy programs sponsored by the right-to-read effort.

WOMEN'S EDUCATIONAL EQUITY

The women's educational equity program, authorized title IV, section 408, of Public Law 93–380, provides funds for public agencies, private nonprofit organizations, and individuals to carry out such activities as the development of materials, preservice, and inservice training, research and development, guidance and counseling, et cetera, which will further educational equity for women.

Fiscal year 1978 was the third funding year. Programs to provide educational opportunities for adult women, including the unemployed and underemployed, are one of the activities authorized under the legislation. The program's regulation requires that all projects reflect understanding that racial, ethnic, social-economic, age, or regional groups "have differing approaches to the provision of educational equity for women."

METRIC EDUCATION PROGRAM

The metric education program, authorized by title III, section 312, of Public Law 95–561, provides grants and contracts to institutions of higher education, and State and local education agencies and other public and private nonprofit agencies in order to prepare students to use the metric system of measurement. The system of weights and measures is used in everyday consumer activities, as well as in international commerce. In order to make effective consumer decisions and sound economic judgments, it is essential that all practicing parties fully understand the units by which goods and commodities are exchanged or purchased. For the most part, the elderly must live within fixed incomes. An effort to meet their educational needs in this regard is critical. One strategy used under the metric education program is to strongly encourage all grantees and contractors to incorporate and delineate techniques by which they will actually teach parents and other adults, including the elderly, to use the metric system as a part of their regular educational and training program.

OFFICE OF HUMAN DEVELOPMENT

February 13, 1979.

Dear Mr. Chairman: The Office of Human Development Services is pleased to comply with your committee's recent request for information on its activities relating to older Americans, for publication in your annual report, "Developments in Aging." This publication is a highly useful reference and we are delighted to assist you in its preparation.

Enclosed are reports on services to older persons by two of our components, the Administration for Public Services and the Rehabilitation Services Administration. You will soon receive the report of the Administration on Aging directly from Commissioner Robert Benedict.

Sincerely,

Arabella Martinez,
Assistant Secretary for Human Development Services.

Enclosures.

Administration for Public Services: Services for the Elderly

The Administration for Public Services has responsibility for administering the social services programs authorized under titles I, IV-A, X, XIV, and XX of the Social Security Act, as amended. Except for Guam, Puerto Rico, and the Virgin Islands, title XX superseded all of the authorizing titles cited above as of October 1, 1975.

Under title XX, grants are made to States for services to eligible individuals based on income or income maintenance status. Certain services can be provided without regard to income, or on a group basis, at State option. States may choose the services they will provide, as long as each service is directed to at least one of the five title XX goals, and at least three services are directed toward supplemental security income (SSI) recipients.

A variety of services directed to assisting needy aged persons to attain or maintain a maximum level of self-care and independence are provided through the social services program. Included are such services as adult day care, adult foster care, protective services, health-related services, homemaker, chore, transportation and other services that assist elderly persons to remain in their own homes or in community living situations. Services are also offered which facilitate entry into institutional care when necessary.

Although data in APS is not collected by age group, it is estimated that approximately $282 million will be expended on services for the aged in fiscal year 1980. This estimate is derived based on 50 percent of the SSI service population which is representative of the aged persons served. The following are estimates of the amounts spent or to be spent on services for the aged during the fiscal years 1977, 1978, and 1979 from funds appropriated to APS.

Fiscal year:	
1977	$249,000,000
1978	259,000,000
1979	280,000,000

Rehabilitation Services Administration: Activities Relating to Older Persons

The major goal of the Rehabilitation Services Administration's program for the aging is to rehabilitate as many older handicapped individuals as possible into gainful employment through activities of the State-Federal rehabilitation program administered by the agency.

The State rehabilitation agencies endeavor to assist each individual to reach his most adequate functioning level and highest vocational potential. This is accomplished through a diagnosis of his condition followed by various services designed to overcome his specific handicap. Throughout the process, the emphasis is on helping the individual to help himself. These services include: evaluation and medical diagnosis to determine the nature and extent of the disability to ascertain capacity for work; counseling to help in developing a good vocational plan; medical care to reduce or remove the disability; vocational training and placement into employment; and followup to insure satisfactory placement.

The Rehabilitation Services Administration cooperates with the Administration on Aging in various activities and projects and will continue to do so. A cooperative agreement, now in the process of being revised, has been established between the Administration on Aging and the Rehabilitation Services Administration. It is designed to bring about improved coordination between the resources of the State-Federal program of vocational rehabilitation and the resources available under provisions of the Older Americans Act of 1965, as amended.

Several innovation and expansion grants are focused on rehabilitation of the disabled aged. These include a project in Wisconsin which provides services by mobile van to counties in the northern part of the State that are not easily accessible; two projects in New Jersey, each of which focused on an increase in staff to expand services for the elderly, and a work opportunity project for the elderly blind in the District of Columbia.

In fiscal year 1978, a special projects designed to expand and improve rehabilitation services for blind people who are at least 55 years of age were active in Hawaii, Nevada, New York, Texas, Illinois, and New Hampshire.

The Rehabilitation Services Administration coordinates with the Social Security Administration in utilizing the social security disability insurance and supplemental security income disabled and blind applicant load as an important referral source of older disabled persons for State vocational rehabilitation services.

It is estimated that there are over 4 million people 45 years of age and over eligible for, and in need of, rehabilitation services, of whom nearly 1 million are aged 65 and beyond. In an effort to alleviate this situation, State rehabilitation agencies have been intensifying their efforts to serve aging handicapped.

Table I gives the number of people rehabilitated; table II the cost data applicable to number of rehabilitants 65 years of age and over.

TABLE I.—NUMBER OF PEOPLE REHABILITATED

Fiscal year	All rehabilitants	45 yr of age and over	65 yr of age and over
1976	303, 328	67, 213	5, 886
1977	291, 328	60, 687	5, 713
1978 (estimated)	294, 000	62, 000	6, 100
1979 (estimated)	299, 000	63, 000	6, 500
1970 (estimated)	284, 000	59, 900	6, 500

TABLE II.—COST DATA APPLICABLE TO REHABILITANTS AGED 65 AND OVER

Type of expenditure	1977	1978	1979 (estimate)	1980 (estimate)
Basic State grants	$15, 544, 000	$16, 725, 000	$17, 491, 000	$21, 120, 000
Innovation and expansion	357, 000	374, 000	414, 000	360, 000
Facility improvement	145, 080	144, 000	144, 000	None
Special projects	488, 700	615, 472	None	None
Training	15, 250	15, 250	15, 250	12, 750

SOCIAL SECURITY ADMINISTRATION

PROGRAMS ADMINISTERED BY THE SOCIAL SECURITY ADMINISTRATION

The Social Security Administration (SSA) administers the Federal old-age, survivors, and disability insurance (OASDI) program (title II of the Social Security Act). OASDI is the basic method in the United States of assuring income to individuals and families when workers retire, become disabled, or die. The basic idea of the cash benefits program is that, while they are working, employees and their employers pay earmarked social security contributions (FICA taxes); the self-employed also contribute a percentage of their net earnings. Then, when earnings stop or are reduced because of retirement in old age, death, or disability, cash benefits are paid to partially replace the earnings that were lost. Current contributions are largely paid out in current benefits. However, at the same time current workers build rights to future benefit protection.

SSA also administers the supplemental security income (SSI) program for aged, blind, and disabled people in financial need (title XVI of the Social Security Act). SSI provides a federally financed floor of income for eligible individuals with limited income and resources. In most cases, SSI supplements income from other sources, including social security benefits.

SSA shares responsibility for the black lung program with the Department of Labor: SSA is responsible, under the Federal Coal Mine Health and Safety Act, for payment of black lung benefits to coal miners and their families who applied for those benefits prior to July 1973 and for payment of black lung benefits to certain survivors of miners.

Local social security offices process applications for entitlement to the medicare program and assist individuals in filing claims for medicare benefits. Overall Federal administrative responsibility for the medicare program rests with the Health Care Financing Administration.

SSA has Federal administrative responsibility for the cash payments part of the aid to families with dependent children (AFDC) program (title IV-A of the Social Security Act). AFDC provides financial aid to needy families with children. The cost is shared by the Federal, State, and local governments. The program is operated by State, local, or county authorities within a framework of conditions set forth in the Social Security Act and Federal regulations.

Also, SSA has Federal administrative responsibility for aid to Indochinese and Cuban refugees.

In addition, the Commissioner of Social Security is the Director of the Office of Child Support Enforcement. That office has Federal administrative responsibility for the program to enforce the support obligations owed by absent parents to their children, locate absent parents, establish paternity, and obtain child support.

Following is a summary of beneficiary levels today, selected program activities, study groups, social security-related legislation enacted in 1978, and related activities:

I. OASDI BENEFITS AND BENEFICIARIES

At the beginning of 1978, about 93 percent of all Americans age 65 and over were drawing social security benefits or were eligible to draw benefits if they or their spouses retired; about 95 percent of the people who reached 65 in 1978 were eligible for benefits. Probably 96 to 98 percent of the aged will be eligible for social security benefits by the end of the century.

At the end of September 1978, 34.4 million people were receiving monthly social security cash benefits (an increase from 33.7 million in September 1977). Of these beneficiaries, 18.2 million were retired workers, 3.6 million were dependents of retired workers, 139,000 were uninsured individuals receiving "special age-72" (Prouty) benefits, 4.9 million were disabled workers and their dependents, and 7.6 million were survivors of deceased workers.

The monthly rate of benefits for September 1978 was $7.8 billion compared to $7.1 billion for September 1977. Of this amount, $5.2 billion was paid to retired workers and their dependents, $991 million was paid to disabled workers and their dependents, $1.6 billion was paid to survivors, and $12 million was paid to special age-72 beneficiaries.

Retired workers received an average benefit for September 1978 of $262 (up from $241 in September 1977), while disabled workers received an average benefit of $287 (up from $264). Retired workers newly awarded social security benefits for September 1978 averaged $281, while disabled workers received average initial benefits of $328. During fiscal year 1978 (October 1977–September 1978), $90.7 billion in social security cash benefits were paid compared to $82.1 billion in fiscal year 1977. Of that total, retired workers and their dependents received $57.7 billion, disabled workers and their dependents received $12.2 billion, survivors received $20.3 billion, and special age-72 beneficiaries received $146 million. In addition, lump-sum death payments amounted to $332 million.

II. SUPPLEMENTAL SECURITY INCOME BENEFITS AND BENEFICIARIES

In 1978, SSI payment levels (like social security benefit amounts) were automatically adjusted to reflect a 6.5-percent increase in the CPI. Thus, begining in July 1978, maximum monthly Federal SSI payment levels increased from $177.80 to $189.40 for an individual, and from $266.70 to $284.10 for a couple.

During fiscal year 1978, over $6 billion in benefits (consisting of $4.8 billion in Federal funds and $1.4 billion in federally administered State supplements) were paid. Of the 4.2 million beneficiaries on the rolls during September 1978, 2 million were aged, and 2.2 million were disabled or blind. During September 1978, total payments of $423.4 million were made. The total payments in fiscal year 1978 represent an increase of about $0.2 billion over fiscal year 1977.

III. BLACK LUNG BENEFITS AND BENEFICIARIES

During September 1978, about 444,000 individuals received $78.5 million in black lung benefits which were administered by the Social Security Administration. These benefits are financed from general revenues. Of these individuals, 141,000 miners and their dependents received $44.9 million, while 146,000 widows and their dependents received $33.6 million. The miners and widows had 158,000 dependents. During fiscal year 1978, SSA administered black lung payments in the amount of $960 million.

Black lung benefits increased by 5.5 percent in November 1978 due to an automatic general benefit increase adjustment under the law. The monthly payment to a coal miner disabled by black lung disease increased to $232 from $219.90. The monthly benefits for a miner or widow with one dependent is $348, and with two dependents is $405.90. The maximum monthly benefit payable when there are three or more dependents is $463.90 .

IV. AFDC BENEFITS AND BENEFICIARIES

Expenditures for 1978 amounted to $12 billion; $10.7 billion was for AFDC payments, and $1.3 billion was for State and local administration of the program. The Federal share of these expenditures was $0.625 billion for AFDC payments and $6.5 billion for administrative costs. The caseload for the year averaged 3.5 million families, with 10.7 million total recipients (of whom 7.5 million were children).

V. OMBUDSMAN PROJECT

During 1977, SSA continued a demonstration project to provide ombudsman-type service for the public in four areas (Boston, Dallas-Fort Worth, and the States of Georgia and Washington). The purpose was to determine whether a service of this type would be an effective way to help satisfactorily resolve, through regular channels, the problems of individuals experiencing difficulties in social security matters. In 1978, based on an evaluation by an independent contractor and his recommendations together with the information and experience obtained by SSA, this project was discontinued. As an outgrowth of this experimental project, however, a new service was instituted, in 1978, whereby district offices designate contact persons to work directly with community groups and organizations that represent people who have special problems with their social security or supplemental security income claims or benefits.

VI. SSA ADMINISTRATIVE GOALS

Five major SSA initiatives with specific management objectives were started in fiscal year 1978. The management objectives, to be achieved by March 1979, are: Improving processing time and accuracy in social security disability claims; improving the administration of the AFDC program, including a reduction in the national payment error rate; reducing processing time and the payment error rate of SSI claims and increasing the number of SSI overpayments processed; increasing collections under the child support enforcement program; and reducing the number of cases pending appeal.

Although the deadline for achieving the objectives has not yet expired, SSA has already met or exceeded its initial goals for processing hearings and appeals, SSI aged claims, SSI overpayment dollars resolved and collected, and for child support case collections.

VII. PUBLIC FORUMS.

Regional forums launched in 1977 by SSA were continued in 1978 to encourage open, frank dialog with the public about social security programs. In 1978, forums were held in Seattle, Chicago, San Francisco, Boston, Des Moines, and, in November 1978, in Baltimore. As many as 400 individuals, usually affiliated with State or local divisions/chapters of national organizations, participated actively in each forum. Their concerns and suggestions were recorded and reports of each forum were prepared and distributed to the forum participants and within SSA for appropriate attention.

VIII. IMPROVING SERVICES TO INDIANS

SSA has developed a comprehensive plan to improve services to Indians. In cooperation with the National Indian Council on Aging, a pilot program will be conducted with the Navajo Nation to adapt SSA public information and training materials to meet the needs of Indians. The information on social security will be given to Indian volunteers who will present it to other members of the Navajo Nation. SSA will also share in a joint program with the Administration for Native Americans, the Administration on Aging, and the National Indian Council on Aging to identify and develop solutions to the problems of elderly Indians, including nonreceipt of benefits to which they are entitled.

IX. ADVISORY COUNCIL

The 1979 statutory Advisory Council on Social Security was appointed in February 1978 to review the financial status of the social security trust funds, the scope of coverage, the adequacy of benefits, and all other aspects of the social security cash benefits and medicare programs.

The Council conducted, in 1978, public hearings in Detroit, Los Angeles, New Orleans, and Miami. They held public hearings in Washington, D.C., on January 4–5, 1979. During these hearings, organizations and individuals expressed special interest in subject areas likely to be studied by the Council:

—Various methods of financing social security programs;
—Social security cash benefit levels;
—Treatment of women under social security;
—The social security retirement test, under which benefits are withheld because of a beneficiary's earnings above specified levels;
—The social security disability insurance program;
—Mandatory coverage of all public employees under social security; and
—Retirement age, including provisions for early and deferred retirement.

Under the law, the Council's report of its findings is to be submitted by October 1, 1979, to the Secretary of HEW for transmittal to the Congress and the Board of Trustees of the social security trust funds.

X. HEW TASK FORCE ON THE TREATMENT OF WOMEN UNDER SOCIAL SECURITY

In November 1977, Secretary Califano appointed an HEW Task Force on the Treatment of Women under Social Security because of his concern that women be treated fairly under the program and in response to a request of the Congresswomen's Caucus that HEW study this matter. The report of the Task Force, released in March 1978, described issues that have been raised concerning the treatment of women under social security and analyzed approaches for dealing with these issues.

XI. OTHER STATUTORY STUDIES

The Social Security Amendments of 1977 provide for a number of specific studies relating to the social security program.

—Study on dependency.—The 1977 amendments provide for an HEW study of proposals to eliminate dependency as a factor of entitlement to spouse's benefits and to eliminate sex discrimination under the social security program. The study will focus on various options for changing the treatment of men and women and families under social security. Cost estimates for various proposals are to be included in the study.
—Universal coverage.—The 1977 amendments direct HEW to study and report on mandatory social security coverage of employees of Federal, State, and

local governments and of nonprofit organizations, in consultation with the Office of Management and Budget, the Civil Service Commission, and the Department of the Treasury. The study will examine the feasibility and desirability of covering these employees under social security. Alternative methods of coverage, alternatives to coverage, and an analysis under each alternative, of the structural changes which would be required in the affected retirement systems and the impact on retirement system benefits and contributions for affected individuals will be considered in this study. The report is due in December 1979.

—National commission.—The National Commission on Social Security, whose members are jointly appointed by the President and Congress, also was established by the 1977 amendments. It will make a broadscale, comprehensive study of the social security program, including medicare. The study will include the status of the trust funds, coverage, adequacy of benefits, possible inequities, alternatives to the current programs and to the method of financing the system, integration of the social security system with private retirement programs, and development of a special price index for the elderly. The Commission is required to submit its final report 2 years after a majority of the members is appointed.

XII. SOCIAL SECURITY-RELATED LEGISLATION ENACTED DURING 1978

Public Law 95-227 (H.R. 5322), the Black Lung Revenue Act—signed on February 10, 1978

Makes part C of the program permanent and establishes a black lung trust fund, supported by a tax on coal. Under this act, where a responsible mine operator can be identified in connection with an approved claim, the payment of benefits will be the obligation of the responsible mine operator. Otherwise, benefits will be paid from the black lung trust fund.

Public Law 95-239 (H.R. 4544), the Black Lung Reform Act of 1977—signed on March 1, 1978

Makes significant changes in both part B and part C of the black lung benefits program. Under the changes, previously denied claimants could have their claims reviewed again, widows of deceased miners could be eligible for benefits if the miner had worked for 25 years in the mines, and rereading of X-rays provided by board-certified or board-elegible radiologists generally would be barred.

The liberalizations in the black lung benefits program provided by the bill impacts heavily on the Department of Labor (DOL), which administers the permanent and expanded part C benefits program. However, SSA also has substantial responsibilities under the bill. SSA is required to review thousands of denied part B benefit claims, respond to many inquiries at local social security offices, and help DOL process new part C applications.

Public Law 95-308 (H.R. 13087), Substitute Treasury Checks—signed on September 22, 1978

Authorizes the issuance of substitute checks (including social security cash benefits, black lung, and supplemental security income checks) without requiring the recipient to sign a statement promising to repay the Treasury Department if both the original and substitute checks were lawfully cashed, except as the Secretary of the Treasury may require.

Public Law 95-458 (H.R. 1337), Federal Cash-Out of Food Stamps for California SSI Recipients—signed on October 14, 1978

Provides for 1 year (through September 1979) a special $10 Federal payment in lieu of food stamps to SSI recipients in California who generally would meet food stamp eligibility criteria.

Public Law 95-472 (H.R. 8811), Definition of wages for FICA and FUTA Tax Purposes—signed on October 17, 1978

Provides that any contribution, payment, or service excludable from an employee's gross income because it is under a qualified group legal services plan would also be excluded from "wages" for FICA and FUTA tax purposes.

Public Law 95-481 (H.R. 12931), HEW Program of Assistance to Soviet Refugees—signed on October 18, 1978

Establishes within HEW a regufee resettlement program for Soviet Jews and other refugees who are not currently covered by existing refugee programs.

Authorizes $20 million in Federal matching payments to voluntary resettlement agencies that assist in the resettlement of such refugees.

Public Law 95–549 (H.R. 12509), Assisance to Indochinese Refugees—signed on October 30, 1978

Extends throught September 30, 1979, 100-percent Federal reimbursement to States for providing assistance to Indochinese refugees who were admitted to the United States under "color of law." Under provisions of Public Law 95–145, Federal reimbursement to States would have been reduced to 75 percent in fiscal year 1979.

Public Law 95–588 (H.R. 10173), Veterans' and Survivors' Pension Improvement Act of 1978—signed on November 4, 1978

Provides a new method of determining VA benefits using the maximum annual VA benefit rate which is reduced dollar for dollar by the other income of the beneficiary (such as social security benefits), including certain income of other family members.

Provides for annual automatic indexing of the maximum annual pension rates to the consumer price index so that VA increases will coincide with increases in social security benefits.

Requires the Government Accounting Office to study: (1) Coordination between VA and SSA of the delivery of veterans' pensions, social security retirement and disability benefits, and SSI benefits; (2) inconsistencies and inequities in the treatment of needy persons; and (3) feasibility and desirability of reconciling unjustifiable differences among those programs in benefit amounts, countable income, asset limitations and accounting periods.

The GAO study is to be submited to Congress by October 1, 1979.

Public Law 95–595 (H.R. 9701), Federal Employees Pension Plans—signed on November 4, 1978

Requires annual reports on the financial status of Federal Government and other public employee retirement plans (other than social security and railroad retirement plans).

Public Law 95–600 (H.R. 13511), Tax Revenue Act of 1978—signed on November 6, 1978

Forgives tax liabilities (including social security taxes) for periods before 1980 of businesses whose workers were treated as independent contractors but later determined by IRS to be employees.

Eliminates the requirement that employers report charge-account tips for tax purposes.

Increases the Federal funds available for grants to States' social services programs from $2.5 billion to $2.9 billion in fiscal year 1979, and makes that amount the permanent ceiling in subsequent years. (For fiscal year 1979 only, $200 million of that amount would continue to be available as 100 percent Federal matching for certain child care activities, as originally adopted in Public Law 94–401.)

Triples the amount of Federal support for assistance programs carried out in Guam, Puerto Rico, and the Virgin Islands and increase the Federal matching rate from 50 to 75 percent.

Makes the earned income tax credit (EITC) permanent. The credit will be equal to 10 percent of the first $5,000 of earned income (up from $4,000), up to a maximum amount of $500. The credit is phased-out at the rate of 12.5 percent of the adjusted gross income (or, if greater, the earned income) as exceeds $6,000. Thus, someone earning between $5,000 and $6,000 is entitled to the full $500, which phases out completely at $10,000. These amendments to the EITC are effective for taxable years beginning after December 31, 1978. In addition, effective July 1, 1979, employers will be required to make advanced payments of the EITC to eligible employees who request them, along with their wages. (The credit will continue to be disregarded for purposes of federally financed public assistance programs, including SSI and AFDC, through December 31, 1979; after that, the credit will be counted as earned income under the programs.)

Public Law 95–602 (H.R. 12467), Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978—signed on November 6, 1978

Authorizes the Secretary of Labor to establish a community service employment pilot program for handicapped individuals. None of the wages, allowances, or reimbursement for transportation or attendant care given to individuals in

this program will be considered as income or benefits for any other program or provision of Federal or State law, unless the Secretary of Labor makes a case-by-case determination that excluding income or benefits, under the employment program, would be inequitable.

Requires HEW to study the impact of vocational rehabilitation services on recipients of benefits under the social security and SSI disability programs. The study will include the cost and savings of services and recommendations for increasing the amount of savings.

Public Law 95-615 (H.R. 9251), Foreign Earned Income Act of 1978—signed on November 8, 1978

Replaces the exclusion from social security coverage of self-employment income earned abroad by U.S. citizens (Public Law 95-30) with an overall income tax deduction for excess foreign living costs effective with respect to taxable years beginning after 1978. If the person so elects, the excess living cost deduction can be used in lieu of the exclusion for the tax year beginning in 1978.

Public Law 95-626 (S. 2474), Health Services Amendments of 1978—signed on November 10, 1978

Provides Federal funds to assist in the establishment of a network of community-based services to aid in the prevention of initial and repeat pregnancies among adolescents.

Public Law 95-630 (H.R. 14279), Financial Institutions Regulatory and Interest Rate Control Act of 1978—signed on November 10, 1978

Prohibits any U.S. Government agency from gaining access to information from a financial institution unless a signed and dated authorization, specifying what records are to be released, is furnished to the institution and agency. The authorization would be good for only 3 months.

ITEM 6. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

JANUARY 19, 1979.

DEAR MR. CHAIRMAN: I am pleased to submit HUD's response to your request for the 1978 report on HUD programs benefiting elderly citizens.

The information contained within will be of use to your committee and to citizens who are interested in the housing and environmental needs of older Americans.

Sincerely yours,

GENO C. BARONI,
Assistant Secretary.

Attachment.

NEIGHBORHOODS, VOLUNTARY ASSOCIATIONS AND CONSUMER PROTECTION

ELDERLY PROGRAMS DIVISION

The Elderly Programs Division (formerly the Office of Elderly and Handicapped Policy), located in the Office of the Deputy Assistant Secretary for Neighborhood and Consumer Affairs, serves as the focal point within HUD for matters pertaining to housing and related facilities and services for the elderly.

Major responsibilities assigned to the organization include participating in the development or revision of HUD policies, programs and procedures affecting the elderly; coordinating HUD elderly initiatives and responses; and representing HUD in activities with other Federal, State, and municipal or private organizations relating to the elderly.

During fiscal year 1978, The Elderly Program Division actively participated in the revision of the section 202 program prior to decentralization to the field. $562 million was awarded this year to sponsors for the construction of over 16,900 units for the elderly.

The division also has had the lead technical responsibility, in a joint effort with Housing, in designing and implementing the congregate housing services program. Under this pilot effort, HUD will enter into 3-5 year contracts with public housing agencies and section 202 sponsors, in which they will then provide meals and other necessary supportives services to elderly and nonelderly handicapped persons to foster independent living and avoid premature institutionalization $10 million is available for fiscal year 1979.

Throughout the year, the division participated in numerous meetings and discussions with other HUD executives and representatives of major organizations representing older Americans and the "aging network." The sessions served to bring to the attention of the Department the immediate concerns of these organizations regarding elderly housing and to suggest ways in which the Department could respond. In turn, the Department was afforded an opportunity to explain its programs and policies with respect to housing the elderly.

HOUSING CONSUMER PROGRAMS DIVISION

The Division of Housing Consumer Programs maintains liaison with the Administration on Aging (AoA) and with national voluntary organizations dealing with the elderly. Numerous meetings have been attended and materials and information on services to the elderly exchanged.

Agreements in effect between HUD and AoA on nutrition and social services for the elderly in HUD-assisted housing, as well as agreements between HUD and DoT and HUD and HEW, continue to produce programs and services. Approximately 1,000 local housing authorities and 100 section 202 projects have provided on-site facilities for the nutrition program during the past year, with some housing agencies acting as grantees and providing additional services such as recreation, health, nutrition education, information and referral, and transportation. These services also benefit elderly residents in surrounding neighborhoods.

The Department is represented on the AoA Task Force on Nutrition, as well as on the Interagency Task Force on Information and Referral. In addition, the Division is represented on the HUD Services Task Force and the Inter-Agency Panel on Adult Education. Through regional coordinators and field office representatives the Division continues to provide technical assistance on services to the elderly.

NEIGHBORHOOD DEVELOPMENT SELF-HELP PROGRAM

Established as part of President Carter's urban policy, the Office of Neighborhood Development supports the efforts of neighborhood organizations engaged in neighborhood revitalization in low and moderate income communities. Many of the neighborhoods which receive technical assistance, information and capacity building funds have large elderly populations. The Office of Neighborhood Development works with community members to fight deterioration and restore social and economic health to their neighborhoods through a wide range of programs such as: tenant organizing, housing rehabilitation, commercial revitalization, economic development, and the improvement of social services.

While many of the 21 local organizations funded by the Office of Neighborhood Development in 1978 are not generally elderly oriented, their activities can and do include projects designed to meet the needs of elderly residents. For example, in a recent contract, the Filmore-Leroy Area Residents, Inc., of Buffalo, N.Y., received $115,000 to develop a home repair industry which will provide low-cost assistance to low-income and elderly residents in making necessary improvements to their dwellings in a 55-square block section of the city.

Also, in another 1978 contract, the Chinatown Neighborhood Improvement Resource Center located in San Francisco's Chinatown will establish a nonprofit corporation to undertake the adaptive reuse of buildings for the elderly. The first project will be the conversion of a local YMCA to low-cost housing for the elderly in the overcrowded China town community.

INTERSTATE LAND SALES REGISTRATION

Congress passed the Interstate Land Sales Full Disclosure Act in 1968, to give the public a measure of protection against fraudulent and deceptive land sales operations. The act is administered through HUD's Office of Interstate Land Sales Registration. Although the act is intended to provide protection for all consumers, it is evident that a great number of potential victims of fraudulent land sales could be the elderly.

The property report is the key to the protection available to consumers under the act, since developers are required by law to give the prospective purchaser a property report before or at the time of signing a contract. The disclosure contained in a property report covers such items as (1) existence of mortgages, liens and other encumbrances; (2) whether contract payments are set aside in a special (escrow) fund; (3) availability of recreational facilities, where and when; and (4) availability of water and sewer facilities or of wells and septic tanks.

During 1978, the Office of Interstate Land Sales Registration has continued with its project to make the disclosure documents easier to understand and to simplify compliance for developers while improving the effectiveness of the act in protecting the interests of consumers including the elderly. The project included the publication of proposed rules for comment as well as the hiring of a contractor to assist in the development of a revised disclosure document which will be easier for the consumer to understand. Public hearings have been held; revised rules and comments have been considered. Revised rules will be published in 1979.

HOUSING

SECTION 8 IMPLEMENTATION

The problems of aging and particularly the housing needs of the elderly are continual concerns of the Department. The implementation of the section 8 housing assistance payments program both assists the construction of elderly housing projects and provides an alternative for those who prefer to avoid living in projects housing only elderly persons.

The section 8 program provides assistance to encourage the construction of new units, the substantial rehabilitation of units, and the use of standard existing units. It encourages the participation of both private developers and public housing agencies. And, importantly, section 8 can maximize the use of the existing housing stock, while inducing production of additional units in markets where the supply of existing housing is inadequate to meet the need, including that of the elderly.

The legislation requires that section 8 projects serve lower-income and very low-income families. Further, some projects are developed with a mix of assisted and unassisted families.

No family assisted under section 8 ay pay more than 25 percent of its income for rent. The rental payment may be as low as 15 percent, however, depending on family income, size, and medical or other unuslal expenses.

Several other features of the section 8 program should be of special advantage to older Americans:

> Eligibility for section 8 assistance has been expanded to include two or more unrelated elderly, disabled, or handicapped persons who are living together, or one or more such individuals living with another person who is essential to their care and well being;
>
> FHA multifamily mortgage insurance programs are available to both section 8 developers and nonprofit sponsors to provide the project financing they need for new construction or substantial rehabilitation. Public housing agencies also may use FHA's section 221(d)(3) market rate multifamily insurance program to finance construction or rehabilitation of section 8 assisted units. (Development for profit-motivated mortgagors will generally use the section 221(d)(4) program or conventional financing.)

Another program feature of particular relevance to elderly citizens is the provision of congregate facilities. The term "congregate housing" generally refers to projects in which some or all of the dwelling units do not have full kitchens, in which the residents are served by a central kitchen and dining facility. This arrangement permits some of the conveniences and economics of communal living to be built into rental projects. Assistance for such housing is available under the public housing, section 202 and section 8 programs. However, there is a statutory limit of 10 percent on the amount of annual contribution contract authority which may be used for this purpose in any fiscal year.

In fiscal year 1978, 108,157 units, or 42 percent of all section 8 contracts were for elderly. About 350,000 units of section 8 have been assigned to elderly use since fiscal year 1976.

SECTION 202—DIRECT LOANS FOR HOUSING FOR THE ELDERLY AND HANDICAPPED

The section 202 program was first introduced as a part of the Housing Act of 1959 to provide direct Federal long-term loans for the construction of housing for the elderly or handicapped. The program was intended to serve elderly persons whose income was above public housing levels but still insufficient to secure adequate housing on the private market. The section 202 program was amended by the 1974 Housing and Community Development Act to change the method of determining the interest rate (previously set at 3 percent) and to provide for the use of section 8 housing assistance payments for projects constructed or substantially rehabilitated under the program. The interest rate, applying to all loans closed through September 30, 1979 is 8⅛ during the construction period and 7⅝ thereafter.

HUD has been authorized to lend $2.35 billion through fiscal year 1978. At the end of fiscal year 1978, 838 projects totaling more than 95,000 units had been approved.

As of December 15, 1978, 231 projects with over 27,500 units were under construction. Funds totaling $800 million for fiscal year 1979, which will provide about 21,000 units, will be available shortly. Section 202 staff are also assisting in developing the congregate housing services program.

PUBLIC HOUSING FOR THE ELDERLY

The public housing program was initiated by the U.S. Housing Act of 1937 (Public Law 412, 75th Congress), "to provide financial assistance to the States and political subdivisions thereof for the elimination of unsafe and unsanitary housing conditions, for the eradication of slums, for the provisions of decent, safe, and sanitary dwellings for families of low-income and for the reduction of unemployment and the stimulation of business activity."

HUD provides technical, professional, and financial assistance to public housing agencies (PHA's) for the planning, development, and management of low-income housing.

Today, the primary goal of public housing is to serve families who cannot afford to pay enough to cause private enterprise in their locality to build an adequate supply of decent, safe and sanitary dwellings for their use. Single persons who are elderly, handicapped, or displaced, are also eligible. To assure that only such families and individuals will be served, income eligibility limits are set and enforced locally.

Amendments to the U.S. Housing Act by the Housing Act of 1956 made it possible to admit as tenants in public housing low-income single persons who were 65 or older. It also authorized the construction of units specifically designed for the elderly. Subsequent legislative changes, such as the Housing Act of 1959, changed the age requirements for elderly persons and families to conform to the Social Security Act (at that time, 65 for men and 62 for woman), and included as "elderly," disabled persons 50 years of age and over; the Housing Act of 1961 changed the eligibility age for males from 65 to 62. As a result of the 1961 amendment to the Social Security Act, the minimum age requirements for persons qualifying as elderly by reason of disability was eliminated. The Housing Act of 1964 permitted admission to low-rent housing of single low-income persons who are displaced by urban renewal or other governmental action, or who are handicapped.

The regulations governing the development of public housing specify that housing for the elderly may be provided if a determination is made by the HUD field office that the housing needs of the elderly are not being met by other HUD-assisted programs proportionately to their share of total housing needs in the jurisdiction of the PHA.

During fiscal year 1978, contract authority was reserved for over 68,000 units (including Indians) of public housing. Overall, public housing contains about 1,300,000 units, 25 percent of which were built for the elderly and handicapped. We estimate about 40 percent of all public housing residents are elderly.

Public Housing staff are also currently working with NVACP to implement the congregate housing services program.

UNSUBSIDIZED PROGRAMS

SECTION 231—MORTGAGE INSURANCE FOR ELDERLY HOUSING

Under section 231 of the National Housing Act, as amended, the Department is authorized to insure lenders against losses on mortgages used for construction or rehabilitation of rental accommodations for older persons (aged 62 years or more, married or single).

Section 231 is HUD's principal program for unsubsidized rental housing for the elderly. Nonprofit as well as profit-motivated sponsors are eligible under the program; section 8 housing assistance payments can be made available. During the year ending Deiember 15, 1978, firm commitments were issued for 50 projects consisting of 5,130 lnits, bringing the total activity under section 231 mortgage insurance to 506 projects consisting of 68, 518 units.

SECTIONS 221(D)(3) MARKET RATE AND 221(D)(4) OF THE NATIONAL HOUSING ACT—MORTGAGE INSURANCE PROGRAMS FOR MULTIFAMILY HOUSING

While these programs are not specifically geared to the elderly, they also are available to sponsors as alternatives to the section 231 program.

Section 221(d)(3) authorizes the Department to provide insurance to finance the construction or rehabilitation of rental or cooperative structures which give preference to tenants who are low and moderate-income single persons under 62 years of age or families with elderly heads of households. Priority in occupancy is given to those displaced by urban renewal or other governmental action. (Because they tend to be residential occupants of older and deteriorating urban neighborhoods, a greater proportion of older persons than younger persons are affected in these areas.) Eighty-four projects containing 8,637 units were insured 1,699 projects containing 143,482 units, of which about 10 percent are for the elderly.

The above features are present in the section 221(d)(4) program except that this program is also available to public and private profit-motivated sponsors.

SECTION 223(F) MORTGAGE INSURANCE FOR THE PURCHASE OR REFINANCING OF EXISTING MULTIFAMILY HOUSING PROJECTS

This program offers mortgage insurance for existing facilities, including housing for the elderly, where repair costs do not exceed 15 percent of project value. The program can be used either in connection with the purchase of a project, or for refinancing only. To the extent that real estate liquidity is enhanced, the availability of section 223(f) encourages investment in residential real estate of all kinds. Prior to its being added to the National Housing Act in August 1974, project mortgage insurance could be provided only for substantial rehabilitation or new construction.

SECTION 232—MORTGAGE INSURANCE FOR NURSING HOMES/INTERMEDIATE CARE FACILITIES

The primary objective of the section 232 program is to assist and promote the construction and rehabilitation of long-term care facilities. Since 1959, when the program was enacted, the Department has insured mortgages for 1,240 facilities providing 141,289 beds.

Approximately 90 percent of the residents of nursing homes are elderly. HEW's medicare and medicaid programs have made it possible for many, who would not otherwise have been able to do so, benefit from the services provided under this program.

During the year ending Septembr 30, 1978, 52 firm commitmnts for insurance covering section 232 projects were issued representing 6,529 beds. Construction starts were achieved for 6,398 units.

The addition of subsection (i) to this program provided for FHA insured supplemental loans to finance installation of fire safety equipment in these facilities. These loans are not limited to section 232 facilities and may provide useful in enabling conventionally financed nursing homes to comply with HEW and State requirements concerning fire safety.

OFFICE OF POLICY DEVELOPMENT AND RESEARCH

Title V of the Housing and Urban Development Act of 1970 authorizes and directs the Secretary to undertake programs of research, studies, testing and demonstrations relating to the mission and programs of the Department. Section 815 of the House and Community Development Act of 1974 strengthened the role of HUD research in the areas of elderly and handicapped by specifically encouraging demonstrations into the problems of members of special user groups, including the elderly and handicapped.

The HUD research program serves as a stimulus for positive change by conducting technological and managerial research, and by demonstrating new methods for application of government and private expertise. The program serves as a national focal point for housing and community development research, and as a central point for research, analysis, data collection and dissemination.

The focus on research related to the problems of the elderly and handicapped is in our program of special user research, although other program areas such as community design research and economic affairs also support research which impacts on the elderly and handicapped.

The mission of the special user group research program is to design, conduct, and support research and demonstration projects whose results will improve housing conditions and related housing and community services for the elderly, the handicapped, and other members of identifiable special user groups. The special user research program is conducted in the Office of the Deputy Assistant Secretary for Research and Demonstration.

CURRENT SPECIAL USER RESEARCH

The Office of Policy Development and Research has recently completed or is currently sponsoring several projects related to the housing problems of the elderly and handicapped; additional projects will be undertaken during 1979. The following list demonstrates the scope of these recently completed and ongoing projects:

—An outreach, orientation and training program for potential minority section 202 sponsors was sponsored. Working in cooperation with the black, Hispanic, Asian, and Indian communities, we identified 586 potential minority group sponsors for section 202 housing. All were invited to attend one of a series of orientation programs offered in seven cities around the country. One hundred fifty-three groups accepted and participated in a one day orientation session which gave a basic overview of the program, its eligibility requirements, the responsibilities of a sponsor and other considerations. Based on information provided by the attendees, 70 groups were invited to participate in a more intensive section 202 seminar. Fifty-three groups accepted the invitation and were given further training in the section 202 application and development process.

—An interagency study of elderly victimization is currently being sponsored by HUD, the Administration on Aging, the Community Services Administration, and the Law Enforcement Assistance Administration in six cities around the country. The project has two purposes: to prevent victimization of the elderly and to provide services for those who are victimized. HUD is providing the funding for the evaluation of the project.

The Office of Policy Development and Research completed a review of the housing situation of the elderly. The purpose was to bring us up to date on the housing needs of the elderly and HUD's response to these needs. The result was a paper, "Housing Options for the Elderly" that (1) presents data on the housing situation of the elderly and on Federal housing programs, (2) evaluates the strengths and shortcomings of current programs, and (3) suggests new approaches. Prior to final editing, the paper was distributed to all of the major elderly organizations and to the key committees of Congress; it will be published within the very near future.

A just completed effort looked at the history of section 202. Not only were there very few minority sponsors in the program in the past, there were very few minority residents in the projects, especially in those projects with majority sponsorship. This new report examines the reasons for these problems and made concrete suggestions to remedy the problem, a great many of which could be implemented administratively.

Work began in 1978 on the design of a longitudinal study of the relationship between important changes which people experience as they grow older and various housing changes which they undertake. The survey, which was pretested in 1978, is to be fielded as a supplement to the annual housing survey in two SMSA's (Houston, beginning in 1979, and St. Louis, starting in 1980), and will be conducted annually through 1988. Some of the housing activities to be investigated include alterations to the physical structures, routine maintenance, and shifting uses of rooms, as well as relocation to a different residence. Individuals selected for inclusion in the first year of the study will be followed during the subsequent years so that the data do not provide a one-sided picture of nonmovers.

Another initiative in 1978 was preliminary work on an evaluation of Baltimore's experimental home maintenance program. The program's objective is to help eligible households living within the target area with minor maintenance and repair problems which, if unattended, can lead to serious deterioration of individual properties as well as negative effects on neighborhood stability. Persons living in the area who are either 55 years of age or older, physically handicapped, or single parent householders are eligible for the program. The evaluation results in 1979 will form the basis for a three-city demonstration of the home maintenance and repair program concept which will be implemented in 1980.

OTHER STUDIES

A cost study of the implications of section 504 for the retrofitting of public housing, combined with a similar analysis of the costs of retrofitting for energy conservation and modernization is underway.

A demonstration of small group homes for the handicapped authorized under section 815 of the Housing and Community Development Act of 1974 continued. This project will provide technical assistance to, and evaluate the development experience of a group of sponsors who are building community based residential facilities for the handicapped through the use of the section 202 and section 8 programs. As a result of this demonstration project, HUD will receive recommendations for establishing a small group home program within the Department. A bibliography on the subject has already been published.

Work continued on the development of a new American National Standard for accessibility for the handicapped, ANSI A117.1. The second round of balloting also resulted in numerous changes to the document. We are now trying to resolve these problems and hope to submit the standard to ANSI early this spring.

Work continued on a followup to the ANSI project, to construct several single-family and multifamily units according to the new standard. Detailed cost analyses will be conducted, as will marketability surveys. Once the units are occupied, followup visits will be made to discuss the usability of the special features of accessibility.

FUTURE RESEARCH

During this fiscal year the following efforts related to the elderly and handicapped will be undertaken:

—The section 202 minority sponsor outreach and training program will be conducted again in 1979, to provide another round of training before the next section 202 advertisement. The National Center for Housing Management and HUD agreed that the short lead time in fiscal year 1978 prevented the identification of many groups and hindered many others from accepting our invitations for orientation and training. We will, therefore, provide the funds for one more round of training.

—An evaluation of the success of the orientation and training in assisting minority sponsors to participate in the program will also be conducted. The Small Business Administration is in the process of entering into an agreement for us under which Mark Battle Associates will examine the effectiveness of the program. The section 202 program has a large percentage of minority applicants in 1978 and awarded a large percentage of the fiscal year 1978 reservations to minority sponsors; but without this evaluation, however, we will not know if this was as a result of our training efforts. The evaluation will examine the experiences of several groups including those which were trained and applied successfully, those which were trained and applied unsuccessfully and those which applied without our training and were still successful.

—A companion to our book "Low Rise Housing for the Older People" will be prepared which will focus on the special design problems of providing mid-rise or high-rise elevator buildings which meet the social needs of the elderly.

—The first round of data collection on the longitudinal study will begin in Houston.

—An evaluation will begin of the demonstration of housing for the severely mentally ill which is being sponsored by the Office of Independent Living for the Disabled.

—The design will begin for the three-city demonstration of maintenance and repair services for elderly homeowners.

—The design work will begin for the evaluation of the congregate housing services program which is being jointly sponsored by the Offices of Housing and Neighborhoods, Voluntary Associations and Consumer Protection. We expect to work closely with HEW evaluation staffs, particularly those of The Administration on Aging and the Rehabilitation Services Administration.

COMMUNITY PLANNING AND DEVELOPMENT

The Office of Community Planning and Development administers programs impacting on the elderly and handicapped under the authority of the Housing and Community Development Act of 1974 and the "701" comprehensive planning and management assistance programs. The authorization is for the conduct of the community development block grant (CDBG) program, the comprehensive planning program, the section 312 rehabilitation program and the urban development action grant (UDAG) Program. These programs are not specifically directetd to the elderly (and handicapped), but activities benefiting these persons are eligible under the 1974 act as amended, and may be carried out by communities receiving community development funds or competing for discretionary monies.

701 COMPREHENSIVE PLANNING ASSISTANCE

The comprehensive planning assistance program provides two-thirds matching grants to all States and some 410 areawide planning agencies, and about 800 localities. Planning for the elderly is a specific eligible activity under the 701 program. Grantees, at their option, may undertake planning for such elderly concerns as availability of affordable housing, the development of improved transportation systems serving the elderly, and the provision of health and other social services for senior citizens.

COMMUNITY DEVELOPMENT BLOCK GRANTS

All information is from fiscal year 1977 as fiscal year 1978 is not yet available.

Chart I presents information on the programming of community development block grant funds for activities in neighborhoods where there is a low (0–9 percent of the population), medium (10–19 percent) and high (20–100 percent) concentration of elderly citizens. Entitlement communities are programing 50 percent of their CDBG funds for areas with a medium (10–19 percent) concentration of elderly.

Chart II shows the distribution of CDBG funds programed for major community development activities by areas of elderly concentration. In areas of high elderly concentration, communities plan to increase the percentage of expenditure for code enforcement, housing rehabilitation and clearance related activities. In areas of medium elderly concentration, communities plan to decrease their percent of expenditure for all residential CDBG funded activity except code enforcement.

The distribution of housing assistance varies by the type of housing assistance planned by local communities. Forty-nine percent of the new construction planned by communities is targeted for elderly and handicapped households. This percentage of assistance would meet nearly fifty percent of the housing assistance goals for the elderly and handicapped in the third program year. Another 28 percent of their housing assistance goals would be met by rehabilitated housing and 22 percent of existing units.

Local plans for fiscal year 1977 called for 37 percent of their total housing assistance to be distributed among the elderly and handicapped. Elderly and handicapped households represent 33 percent of the total needy population.

A performance report for fiscal year 1975–76, based on a 147 cities sample, shows that of housing for which a financial commitment was made, 44 percent of the units are to benefit the elderly and handicapped. In this same time period, the elderly need was 33 percent of the total need for local housing assistance. Performance data also shows the 68 percent of new construction financially committed during fiscal year 1975–76 was for the benefit of the elderly and handicapped.

4 i

CHART I.—PERCENTAGE OF TOTAL EXPENDITURE OF FUNDS BY PERCENT OF ELDERLY CONCENTRATION BY NEIGHBORHOOD LOCATION, 1976 AND 1977

Neighborhood location	Low concentration (0-9 percent)		Medium concentration (10-19 percent)		High concentration (20-100 percent)		total (percent)
	1976	1977	1976	1977	1976	1977	
Residential	31.5	39.0	60.9	54.0	7.6	7.0	100
Central business district	9.6	14.4	54.4	54.7	36.0	30.9	100
Other commercial areas	25.6	40.1	59.6	48.0	14.9	11.1	100

CHART II.—PERCENTAGE OF RESIDENTIAL EXPENDITURES ON CDBG FUNDED ACTIVITY BY PERCENT OF ELDERLY CONCENTRATION, 1976; 1977

CDBG funded activity	Low concentration (0-9 percent)		Medium concentration (10-19 percent)		High concentration (20-100 percent)		Total (percent)
	1976	1977	1976	1977	1976	1977	
Clearance related	33.2	42.5	59.1	48.4	7.8	9.2	100
Code enforcement	33.7	30.0	59.7	61.0	6.6	8.2	100
Public works	27.1	32.9	64.3	59.6	8.6	7.5	100
Housing rehabilitation loans and grants	28.9	34.3	64.2	57.5	6.9	8.1	100
Services related	27.2	55.1	61.4	42.4	11.3	2.5	100
Public services	35.8	43.0	56.4	51.2	7.7	5.8	100

URBAN DEVELOPMENT ACTION GRANTS (UDAG)

The urban development action grant program provides grants to cities and urban counties which meet certain minimum standards of physical and economic distress. Activities eligible under the community development block grant program are also eligible for UDAG funding, but in order to receive funding, projects must provide jobs and substantial private investment of funds. Activities benefitting the elderly, such as construction of housing for the elderly, housing rehabilitation loan programs, and construction of nursing homes would be eligible assuming that the project is competitive with others under consideration.

Funds from the UDAG program can be also used to carry out a variety of commercial and neighborhood based revitalization activities such as attraction of industry, and improving commercial physical plants. Many cities have innovatively packaged a number of these approaches. For example, one neighborhood in Newark, N.J., used $400,000 in UDAG funds to attract over $2,000,000 in private funds for low and moderate income new and renovated housing, and a shopping center containing a supermarket, in an area sorely lacking shopping and other amenities. Many of the 95 percent plus minority residents of this local are elderly.

SECTION 312 REHABILITATION LOANS

Section 312 loans are direct loans to owners, and sometimes tenants, of properties located in specific HUD assisted areas, the most common being community development block grant activity areas. The localities and cities receiving HUD block grant assistance process loan applications in conformance with the law and the regulations. The Congress has directed that priority be given to low and moderate income applicants or to applications of multifamily structures where the majority of tenants are of low and moderate income. Because so many of the elderly are low and moderate income persons the rate of loans and dollars for the elderly in this program has steadily increased. Through 1976, 17 percent of the number of loans and 12 percent of the dollar amount went to applicants 62 years of age or older. In the next 2 years the rates were 21.2 percent for the number (an increase of 4 percent of the total) and 15.3 percent of the dollar amount (an increase of 3 percent of the total).

FEDERAL DISASTER ASSISTANCE ADMINISTRATION

POLICY AND TRAINING

The Administrator placed increased emphasis on delivery of disaster assistance to the elderly. He stressed his intent to develop in FDAA employees special awareness and skills in identifying and resolving special problems of elderly disaster victims, through the cooperation of the Administration of Aging (AoA) at the national level and through State and local officer for aging (the aging network). To implement this policy, emphasis, a special training conference was held on October 4, 1978 for FDAA regional individual assistance officers and public information officers. Various presentations, including one from a staff member of the Senate Special Committee on Aging, were made—all of which stressed the need for concentrated efforts to help the elderly who may be unable themselves to secure available disaster assistance. The presentation also stressed the relationship between consumer counseling for all disaster victims and special counseling for the elderly. As a part of this new emphasis on special services FDAA also as emphasizing consumer protection in the delivery of disaster assistance. Special publications and news releases advising disaster victims of consumer affairs problems (contracts, home repair, warranties) have been widely distributed.

During the last few months of 1978, the Administrator also corresponded with program administrators for the Food and Nutrition Service, Department of Agriculture and the Federal Insurance Administration, HUD, regarding special services for the elderly. These contracts were made in response to inquiries by the Luzerne/Wyoming Counties (Pa.) Office for the Aging. Concerning food stamps, FDAA has been informed that new initiative are under study in FNS which would directly benefit elderly disaster victims. FIA has also advised us that a three-year flood insurance policy is being studied; it would eliminate yearly administrative costs of servicing a policy, therefore resulting in lowered premiums.

PLANNING

Several staff members of FDAA participated in the planning meetings of the National Advisory Committee on Disasters in the preparation of a model disaster plan for the aging network, particularly area agencies on aging (AAA's). Under the chairmanship of the New York State Office on Aging, the advisory committee helped draft and revise a sample plan for adoption by AAA's, which is currently being published. The plan will improve the ability of the AAA's to provide for needs of the elderly in disaster situations—both in those where supplemental assistance by FDAA is required (a major disaster declared by the President under P.L. 93-288), and when no supplemental assistance is required but elderly are affected. When the plan is published in late January, FDAA will assist in its distribution and will instruct the FDAA Regional Offices to provide technical assistance to any AAA wishing to adopt a disaster readiness posture or to establish a formal relationship with FDAA.

PROGRAM

The most noteworthy program innovation with FDAA concerning the elderly during fiscal year 1978 occurred as a response to the President's declaration of a major disaster for severe flooding in the Rochester, Minn. area in July 1978. The Federal coordinating officer identified a large percentage of elderly in the area who would require services in order to obtain available disaster assistance. In response, the Regional Director, FDAA Region 5, assigned the Southeastern Minnesota AAA to provide outreach and other services. Approximately 1,000 elderly and disabled disaster victims were provided information and referral services, help in filling out disaster assistance application forms, resource identification and followup, and transportation services.

COORDINATION AND COOPERATION

Other FDAA regions continue to call upon the AAA's and the State offices on aging for advice and assistance in Disaster Assistance Center operations, where required; FDAA's national office maintains liaison with the Commissioner on Aging's disaster response personnel. FDAA recognizes the valuable services AoA can provide under its own legislation, and also recognizes the areas where, with funding assistance, AoA can use its expertise in providing and supplementing services authorized by the Disaster Relief Act. FDAA will continue to implement the memorandum of understanding with AoA, and will propose to the Director of the new Federal Emergency Management Agency that he/she retain this understanding in the new agency. If mission assignments are required to carry out disaster assistance goals for the elderly, FDAA will make the assignments and provide the funds to supplement those already available under the Older Americans Act, as amended. In this way, the services will be carried out mutually by the two agencies to the benefit of disaster victims.

NEW COMMUNITY DEVELOPMENT CORPORATION

Through legislation passed in 1970, the Federal Government can guarantee mortgages for developers of large scale new communities which meet certain requirements, including provision of an economic base, provision of substantial amounts of low and moderate income housing, good physical and social planning, and provisions of adequate community amenities and facilities including education, health, culture, and recreation.

New community projects approved for Federal assistance will provide housing, community facilities, and amenities which will have special value to the elderly and handicapped. These include barrier-free access to public buildings, pathway systems separated from vehicular traffic, and ready access from homes to shopping, recreational facilities, and neighborhood facilities.

RESEARCH

In coordination with HUD's Office of Policy Development and Research The New Community Development Corporation has sponsored a research study to design whole villages in new communities to be barrier-free and thereby accessible to the elderly and handicapped. Two new communities, St. Charles, Md., and Harbison, S.C., were used as case studies to develop a process, manuals, design and cost materials for barrier-free planning. Both new communities have pledged to implement the recommendations of the study.

The contractor, Peoples Housing Inc., submitted a draft final report for review by the New Communities Development Corporation staff as well as staff of the Office of Policy Development and Research. From this review came recommendations for revision in the format and presentation of the study. The contractor has been notified that proposed changes are necessary and is willing to revise the final report to reflect HUD's recommendations. This process is now taking place. The final report will be available to the public, as will a slide presentation which describes the sensitizing process used in the study.

NEW COMMUNITY PROJECTS

Three of the HUD assisted new communities have completed housing projects for the elderly. On Roosevelt Island, N.Y., 284 units for the elderly and handicapped have been completed, and rented. The developer continues to work with the city of New York on programs to utilize the 8,000 square foot ground floor activity center, which contains offices, meeting rooms and a fully-equipped kitchen and dining facilities. Roosevelt Island residents have ready access to health services offered by existing hospitals on the island. Barrier-free access to building and facilities is provided in the new community design and the apartment structures are multiuse, some containing schools and social services. Private autos are banned from the island's streets and minibus transportation provides ready access throughout. An aerial trainway is now operating between the island and Manhattan.

St. Charles, Md., opened a 96-unit housing project assisted by 221(d)(4) financing. Half of these units are rented by elderly persons. St. Charles also has 104 units of section 236 housing for the elderly under construction with some of the units already occupied. Both these projects consist of single-story quadraplex housing, making them more easily accessible to elderly and handicapped. Additionaly, they are sited to be convenient to shopping and transportation. Finally, St. Charles will start construction on a 150 unit section 8 elderly project in the spring of 1979.

Park Forest South built a 14-story 183 unit section 236 elderly project in 1975 which is fully rented and adjacent to a neighborhood shopping area.

Four more of the HUD assisted new communities have elderly housing under construction or in processing. Woodlands, Tex., has 144 units of section 8 under construction and another 156 units of section 8 in processing. Harbinson, S.C., has a 110 unit section 202/8 project that will go under construction in the summer of 1979. Jonathan, Minn., has a 114 unit section 8 project under construction. Park Central, Tex., has a 150-unit section 8 project in processing which will go under construction in 1979.

INTERAGENCY COOPERATION

SERVICES TO THE ELDERLY IN HUD-ASSISTED HOUSING

HUD and the Administration on Aging have identified joint objectives to promote maximum coordination, using HUD's section 202 programs and AoA's title III and VII programs to provide joint planning programing and implementation of activities which will:

(1) encourage the development of comprehensive coordinated services to older persons in HUD-assisted housing, and focus on the inclusion of such services in new and substantially rehabilitated housing.

(2) Encourage the involvement of elderly citizens in the planning of projects proposed under section 202/8;

(3) Promote maximum cooperation between HUD's Neighborhood and Community Affairs Representatives, and AoA's regional, State, and area agencies on aging; and

(4) Provide joint training or technical assistance for HUD field staff administering the production and management of the section 202 program with respect to the social aspects of site selection, architecture, service space requirements, project management, function and responsibilities of sponsors, available social services and related matters dealing with elderly and handicapped.

INTERDEPARTMENTAL AGREEMENTS

NUTRITION—TITLE III (PER THE 1978 AMENDMENTS TO THE OLDER AMERICANS ACT)

HUD recognizes that it and the Administration on Aging (AoA) share a common interest in serving residents of elderly housing through the title III nutrition program for older Americans and that a number of HUD housing developments for the elderly can offer facilities in their community space to serve as sites for the AoA nutrition projects, serving at least one hot meal a day not only to residents of the development but also to other elderly of the community.

Therefore, local housing authorities and the management of other HUD assisted housing for the elderly have been altered by HUD field offices to make contact with the State agency in aging. They also identified the number of elderly residents reachable through the housing development; informed the State agency on aging about the community space and facilities that can be made available; ascertained from the State agency on aging how and when nutrition funds can be utilized to accomplish alterations necessary in community space to accommodate meal preparation and service, recommended so doing.

TRANSPORTATION

Management of HUD-insured housing for the elderly, section 202 direct loan projects, and local housing authorities have been urged to establish and maintain relations with their local transit authority and to explore: working with the local government to implement reduced rates for the elderly and handicapped; adjusting schedules to accommodate the special transportation needs of the elderly and handicapped; and obtaining from local transit authorities special services, facilities or lowered fares.

The management of HUD-assisted housing for the elderly and handicapped and local housing authorities also post the transit maps and transit schedules of local transit authorities.

ENERGY

The department advises its field office about elderly related energy conservation efforts and suggests that these offices provide state and area offices on aging with information concerning HUD home repair programs. In addition, the Department suggests to its field offices that they initiate discussions with state and area agencies on aging concerning the use of community space in HUD-assisted elderly projects for energy conservation related activities.

INFORMATION AND REFERRALS

The Department is providing to the National Clearing House on Aging, on a continuing basis, directories of HUD-assisted housing for the elderly and HUD issuances pertaining to the elderly, and has reaffirmed the fact that HUD area and insuring offices can answer general questions on elderly housing availability, eligibility for occupancy and questions of this nature. In addition, the Department has agreed that HUD-assisted projects can provide a conduit for appropriate aging information and materials, and that these elderly projects may, in some instances, be able to provide information and referral sites in community space.

A member of the Community Service staff represents HUD and attends regular meeting of the Interdepartmental Task Force of Information and Referral. The Task Force has produced an "I & R Guide," which has been distributed to all HUD field offices for their information and distribution to agencies and organizations in their jurisdictions.

HUD/AOA AGREEMENTS

Efforts are underway to rewrite both the Nutrition and the Social Services portions of the existing interagency agreements to combine these agreements and possibly title XX of the Social Security Act into a single agreement. In addition, community development programs affecting the elderly will be included, together with other HUD programs.

ITEM 7. DEPARTMENT OF THE INTERIOR

BUREAU OF INDIAN AFFAIRS

DECEMBER 21, 1978.

DEAR MR. CHAIRMAN: This responds to your letter of December 1, 1978 to the Secretary of the Interior, and is an updated review of what is happening with our programs related to the aging.

With the signing of Public Law 95–478, title VI, Grants for Indian Tribes, became a new part of the Comprehensive Older Americans Act Amendments of 1978. This recognition and promotion of the delivery of social services, including nutritional services for Indians is a giant step forward for the senior Indian American. Tribes will be eligible for grants through the Older Americans Indian Act and will be able to develop their own programs and service-delivery systems through this enabling legislation, coupled with the 93–638 Indian Self-Determination and Education Assistance Act (35 U.S.C. 4506).

As we received copies of the legislation, we issued memorandums to all area field offices and agencies and requested that tribes be contacted for their viewpoints. We are also requesting that estimates be made of the underutilized or unused education facilities which might be made available for elderly program use, and we are participating with the Administration on Aging in development of the regulations.

The Bureau of Indian Affairs Program of Social Services undertakes to provide necessary assistance and social services on reservations when such assistance and social services are not available through State or local public welfare agencies. The bureau administers such programs on every major Indian reservation.

Indians on reservations are eligible for benefits under the Social Security Act on the same basis as non-Indians. Persons eligible for these programs are not eligible for BIA financial assistance. An exception is made for elderly Indians on reservations who are eligible for SSI benefits but whose cost of care in a nursing home or other nonmedical facility exceeds the amount of the SSI payment. In these instances, BIA financial assistance is provided as needed and an application for SSI benefits is not required as BIA assistance, unlike that of the States, is considered income under SSI legislation.

The Bureau of Indian Affairs also provides technical assistance and support to the tribes and to Indian organizations. We are continuing to provide support services for the National Indian Council on Aging, located in Albuquerque, N.M.

We appreciate the opportunity to contribute to your report.

Sincerely,

RICK LAVIS,
Deputy Assistant Secretary, Indian Affairs.

HERITAGE CONSERVATION AND RECREATION SERVICE

DECEMBER 18, 1978.

DEAR MR. CHAIRMAN: I am pleased to reply to your letter of December 1, 1978, to the Secretary of the Interior, Cecil D. Andrus, concerning Federal actions and programs related to aging.

The Heritage Conservation and Recreation Service continues to emphasize the needs of the disabled, particularly the handicapped and the aged, in its recreation and heritage conservation programs. Projects under our land and water conservation fund program are required to provide access to recreation facilities and enhance opportunities to the handicapped and other persons with special needs, such as the aged. Similar requirements apply to the historic preservation fund program. Projects under this program are not only museum-related, as they may include the reuse of residential, commercial, and industrial buildings—buildings in which people of all walks of life, including the aged, live and work. And under the surplus property program, properties transferred to State and local governments may be used to satisfy the recreation needs of special populations, including senior citizens.

The Federal recreation fee program continues to be one of our most successful programs benefiting the aged. As you know, under this program the Golden Age Passport is issued free for the lifetime to persons 62 years of age or older who are citizens or permanent residents of the United States. The passport entitles them to enter, at no charge, the national parks, monuments, and recreation areas managed by the Federal Government. It also provides 50 percent discount on Federal "use" fees charged for facilities and services such as camping, boating, parking, etc. It does not cover fees charged by private concessioners.

The passport may only be obtained in person after showing proof of age such as a State driver's license or birth certificate. Passports are available at National Park Service offices and areas of the National Park System where entrance fees are charged, most Forest Service offices and ranger stations, and Bureau of Land Management offices. It is not available at post offices.

Sincerely,

CHRIS THERRAL DELAPORTE, *Director.*

ITEM 8. DEPARTMENT OF JUSTICE (LAW ENFORCEMENT ASSISTANCE ADMINISTRATION)

DECEMBER 29, 1978.

DEAR MR. CHAIRMAN: This is in response to your request for input from the Law Enforcement Assistance Administration for "Developments in Aging," which will be published in February 1979.

In February 1978, a statement on "LEAA Programs for Senior Citizens" was prepared for the use of the Special Committee. A copy is enclosed for reference.[1] Because the agency's authority to support programs for the elderly has not been changed since that date, the information contained in the statement is pertinent to your current investigations.

On December 22, 1978, Henry S. Dogin, Deputy Administrator for Policy Development, LEAA, wrote to the Special Committee in conjunction with hearings on "Older Americans in the Nation's Neighborhoods." A copy of that letter [1] is enclosed for your use in "Developments in Aging," since it provides additional information on LEAA activities which assist senior citzens, partcularly recent projects supported by the Agency's Office of Communty Anti-Crime Programs. Also enclosed for the information of the Special Committee is a complete listing of LEAA categorical awards from fiscal year 1969 to the present relating to elderly programs, and the publication "Crime Prevention Handbook for Senior Citizens," issued by LEAA's National Institute of Law Enforcement and Criminal Justice.[1]

---

[1] Retained in committee files.

I trust this material will be useful to your deliberations. The continued interest of the Special Committee on Aging in the programs of the Law Enforcement Assistance Administration is appreciated.

Sincerely,

STEPHEN T. BOYLE,
Director, Office of Congressional Liaison.

ITEM 9. DEPARTMENT OF LABOR

MARCH 19, 1979.

DEAR MR. CHAIRMAN: Enclosed, as per your request, is a summary of the programs and activities of the Department of Labor for 1978 related to aging. This summary describes the services provided under programs administered by our Employment and Training Administration, Employment Standards Administration and pension and welfare benefits program. I hope this will be of assistance to you in preparing your report, "Developments in Aging."

Sincerely,

RAY MARSHALL,
Secretary of Labor.

Enclosures.

SUMMARY OF EMPLOYMENT STANDARDS ADMINISTRATION ACTIVITY AFFECTING AGING

Department enforcement activities under the 1967 Age Discrimination in Employment Act (ADEA) continued to grow during fiscal year 1978. Although a full report will be contained in the Department's forthcoming annual report to the Congress as required under section 13 of the act, some preliminary statistics are available.

Enforcement activities continued to concentrate investigative resources on the development of cases affecting large groups of workers. During 1978 a record $14.5 million in damages was found owing to 4,111 persons, representing a substantial increase over the previous record year 1977, when $10 million was found owing to 1,943 persons. Included in the 1978 total of $14.5 million is $13 million found due 3,850 persons as a result of fact-finding investigations. The remainder resulted from conciliations in which employers, employment agencies, or labor organizations agreed to pay damages without being formally charged with violations of the act. The act provides that the Secretary use informal methods of conciliation in an attempt to achieve voluntary compliance. During fiscal 1978, successful conciliations rose by approximately 24 percent over 1977.

A total of $4.8 million was actually restored to 1,363 persons during fiscal year 1978, as a result of both conciliation and fact-finding investigations. Most of the difference between findings and restorations is involved in cases that have been referred to the Solicitor of Labor for consideration of legal action. During 1978 (calendar year) the Department filed 38 lawsuits under the ADEA. Significant cases decided during the year established precedents regarding the use of statistics in pattern and practice cases, burden of proof, and procedural issues.

In addition to the payment of damages, enforcement activities also succeed in insuring that future wages, health and life insurance benefits, and hiring and promotion opportunities will be enjoyed by older workers. First-year future compensation (wages, pensions, health and life insurance benefits, and so forth) obtained as a result of enforcement efforts by the Department were projected to exceed $3.5 million to over 1,000 persons.

On April 6, President Carter signed into law the ADEA Amendments of 1978. The amendments bar mandatory retirement before age 70 for most private sector workers and non-Federal public employees, and eliminate mandatory retirement for most Federal employees. The Department is in the process of developing interpretations and regulations to implement the 1978 amendments. Proposed interpretations and regulations have been issued or are now being drafted with regard to the impact of those amendments on employee benefit plans and retirement policies, and the implementation of statutory exemptions for certain executive and high policymaking personnel and tenured employees at institutions of higher education. The Department is also in the process of contracting for studies of the possible effects of barring mandatory retirement altogether, as well as the impact under the 1978 amendments of raising the upper age limit from 65 to 70 and of the exemptions for tenured employees at institutions of higher education and certain high-level executives.

Enforcement responsibility under the ADEA is scheduled to shift from the Department to the Equal Employment Opportunity Commission on July 1, 1979. The Department is currently engaged in working with the Commission to prepare it for assuming this responsibility, and to assure an orderly transfer. Until the transfer is effected, the Department will continue to vigorously carry out its mandate under the act.

EMPLOYMENT AND TRAINING ADMINISTRATION SERVICES TO OLDER WORKERS

BACKGROUND

Within the broad framework of the Wagner-Peyser Act of 1933, as amended, which established the Federal-State employment service system, the State employment services provide intensive counseling, assessment, job development, placement, and referral to training and social services to meet the employment-related needs of middle-aged and older jobseekers.

The ultimate objective of these services is to minimize the duration of unemployment experienced by men and women who lose their job when in their midforties or later years, and to assist all middle-aged and older workers in obtaining and remaining in employment which utilizes their highest skills.

Although the unemployment rate for middle-aged and older workers is lower than for the younger age groups, the duration of unemployment experienced by men and women who lose their job when in their midforties or later tends to increase. The Age Discrimination in Employment Act of 1967, as amended, recognizes this trend in its coverage of most workers who are at least 40 years of age but less than 70. For purposes of recordkeeping and statistical reporting, the employment service uses age 45 as a reference point for the term "older worker."

FISCAL YEAR 1978 ACCOMPLISHMENTS

Although the total intake of jobseekers age 45 and over decreased 10.1 percent, all major service indicators showed an increase in the number of older workers served. The attached table, "Employment Services for Older Workers," provides data comparing public employment services to jobseekers age 45 and over and 55 and over to all applicants regardless of age.

In fiscal year 1978, a total of 133,833 veterans age 45 and over were placed in jobs by the State employment services. This is a 6-percent increase in older veterans placed over fiscal year 1977.

Older worker specialist training materials prepared by the Minneapolis Rehabilitation Center under contract to the Minnesota Department of Employment Services were used for initial an drefresher training of State agency staff serving older workers.

The public employment services in Arkansas, California, Florida, Georgia, Illinois, Ohio, Michigan, and Texas supplemented their regular staff resources in selected local offices by the use of specially trained low-income retired men and women who work on a half-time basis providing intensive job development and community outreach services for applicants age 55 and over.

State employment services participated in the annual observance of National Employ the Older Worker Week to emphasize year-round public employment services to older jobseekers.

A staff member of the U.S. Employment Service served on the Interdepartmental Task Force on Information and Referral created by the Cabinet-level Committee on Aging established under the Older Americans Comprehensive Services Amendments of 1973 (Public Law 93-29). The task force is concerned with implementation of the Interdepartmental Agreement on Information and Referral for Older People signed by the Employment and Training Administration and 13 other Federal departments and agencies on December 21, 1974.

FISCAL YEAR 1979 INITIATIVES

(A) Promotional and technical support for State employment service participation in the 1979 observance of National Employ the Older Worker Week has been provided.

(B) Continued involvement in the Interdepartmental Task Force on Information and Referral.

(C) Initial and refresher training of all new and on-board local office staff serving older workers is being encouraged. State employment services will provide staff training as needed in older worker counseling and placement techniques.

(D) Continued promotion of public employment service cooperation with State and area agencies on aging and other organizations concerned with employment of older people.

RESEARCH AND DEVELOPMENT

The Employment and Training Administration's Office of Research and Development conducts a program of research and demonstration projects to improve and/or develop new employment, training, and income maintenance programs, policies, and initiatives. A number of these projects are aimed at older workers.

RECENTLY COMPLETED PROJECTS

A major project completed in 1978 was the Research and Development Strategy on Employment-Related Problems of Older Workers. Conducted by Dr. Harold Sheppard of the American Institute for Research, this work includes a systematic examination of all relevant older worker data, a review and evaluation of ongoing older worker programs, and an analysis of older worker policy issues and priorities. This study is expected to provide guidance for older worker R. & D. programs over the next 5 to 10 years.

The Office of Research and Development recently sponsored a survey of 600 elderly Hispanic Americans in Riverside, Calif., to study their participation in employment and training programs under the Comprehensive Employment and Training Act (CETA) and the Older Americans Act. The major findings of the survey are that elderly Hispanic Americans have a low participation rate in these programs and that their knowledge or awareness of the programs is minimal. It has been recommended that programs should be developed which are aimed specifically at the Hispanic elderly and staffed with bilingual-bicultural personnel.

Another project sponsored by the Office of Research and Development was the national program for selected population segments (NPSPS). One of the target groups of this project was older workers. In two areas this project trained older persons as homemaker or health aides to assist other elderly persons confined to their homes. Unexpectedly, many trainees qualified for nurses aide or orderly certificates as a result of their training. Many took full time jobs in hospitals and nursing homes in addition to working in private homes. In two other areas, the project offered more general counseling and placement assistance for elderly persons who may have been forced into early retirement. In another area, the NPSPS project for older workers coordinated existing services for the elderly and provided them with information concerning these services. The project paid the wages of 21 senior citizen coordinators who provided these information and referral services for other elderly persons in the community.

ONGOING PROJECTS

A major effort supported by the Office of Research and Development is the National Longitudinal Surveys of Labor Force Behavior. One of the groups studied is men who were aged 45 to 59 in 1966. The men in the group are surveyed at regular intervals. The surveys focus on the interaction among economic, sociological, and psychological variables that permit some members of a given age-education-occupation group to have satisfactory work experiences while others do not. The United States Bureau of the Census draws the samples and collects and tabulates the data for the National Longitudinal Surveys. Ohio State University prepares the data collection schedules, plans the tabulations, analyzes the results, prepares reports on the surveys, and will write a final comprehensive report for each group studied. Reports on many of the surveys are reproduced as research and development monographs.

A project analyzing the National Longitudinal Surveys data will estimate the effects of social security benefits on retirement rates of men over age 62 and the effects of aging on earnings and labor supply. The factors to be studied include ill health, forced retirement, other layoffs, and the availability of private pension income.

The Office of Research and Development gives grants to universities to support doctoral dissertation research. Two of these dissertation grants support analyses of the National Longitudinal Surveys of older men. The first, being written at Yale University, is a study of early retirement and its effects with the objective of developing information on pensions, unemployment compensation, social security, and other retirement-related areas. The second dissertation, being written at Cornell University, is an attempt to derive a theoretical model for determining the labor participation/labor supply decisions of older males. This model takes into account not only the impact of the aging process and health factors on the retirement decision but also the effect of public policy directed at the welfare of the aged. It is expected that the methodology developed will make it possible to generalize on the entirely of the available labor supply responses of older workers.

A recently started study is concerned with the feasibility of using retired teachesrs to make a significant impact on the solution of educational problems in the District of Columbia. Consideration will be given to employing retired teachers on a voluntary basis in supplementary educational and extracurricular activities for full-time students as well as in community and adult education programs, including programs for senior citizens.

EMPLOYMENT SERVICES FOR OLDER WORKERS, FISCAL YEAR 1978

Employment services for older workers	Fiscal year 1978 (all fund sources)			Change from a year ago[1] (percent)		
	Total	Age 45 and over	Age 55 and over	Total	Age 45 and over	Age 55 and over
New applications and renewals	15,461,000	2,015,700	846,900	−2.2	−10.1	−10.7
Individuals referred to job openings	8,269,700	INA	INA	+7.6	INA	INA
As percent of new applications and renewals	53.5			(48.6)		
Individuals placed in a job	4,623,300	408,700	153,600	+11.7	+5.3	+8.7
As percent of individual referrals to job openings	55.9			(53.8)		
As percent of new applications and renewals	29.9	20.3	18.1	(26.2)	(17.3)	(14.9)
Individuals counseled	1,048,100	122,700	42,600	+9.1	+14.4	+22.3
As percent of new applications and renewals	6.8	6.1	5.0	(6.1)	(4.8)	(3.7)
Individuals placed after counseling	296,000	26,000	8,500	+12.4	+18.1	+28.8
As percent of individuals counseled	28.2	21.2	20.0	(27.4)	(20.5)	(18.9)
As percent of new applications and renewals	1.9	1.3	1.0	(1.7)	(1.0)	(.7)
Individuals enrolled in training	189,400	9,600	2,400	+6.6	+15.8	+26.5
As percent of new applications and renewals	1.2	.5	.3	(1.1)	(.4)	(.2)
Individuals referred to supplemental service	922,200	128,500	48,800	+24.1	+22.4	+26.4
As percent of new applications and renewals	6.0	6.4	5.8	(4.7)	(4.7)	(4.1)
Individuals for whom job development contacts were made	1,472,600	199,300	74,300	+12.4	+16.0	+22.1
As percent of new applications and renewals	9.5	9.9	8.8	(8.3)	(7.7)	(6.4)
Individuals placed as a result of job development	563,900	56,600	21,200	+3.0	+2.1	+7.6
As percent of new applications and renewals	3.6	2.8	2.5	(41.8)	(32.3)	(2.1)

[1] Fiscal year 1977 percentages shown in parentheses for comparison.

COMPREHENSIVE EMPLOYMENT AND TRAINING PROGRAMS AND PUBLIC SERVICE EMPLOYMENT PROGRAMS

Persons in all working age groups participate in activities under the Comprehensive Employment and Training Act (CETA), which provides for comprehensive employment and training programs and public service employment. On October 27, 1978 President Carter signed the CETA amendments of 1978 (Public Law 95-524) into law; one of the changes in the statute was a major reordering of programs under different titles. The following table indicates the numbers of persons in the upper age groups who participated in comprehensive employment and training programs (old title I) and public service employment (old title II and VI) during fiscal year 1978 (October 1977–September 1978) and the persons who fell into these age groups.

CETA, FISCAL YEAR 1978

	Total	Percent	Title I	Percent	Title II	Percent	Title VI	Percent
Total participants	2,558,600		1,331,500		210,200		1,016,900	
45 to 54	161,700	6.3	58,600	4.4	18,700	8.9	84,400	8.3
55 to 64	84,000	3.3	30,600	2.3	9,700	4.6	43,700	4.3
65 and over	24,600	1.0	13,300	1.0	2,100	1.0	9,200	0.9
45 and over	270,300	10.6	102,500	7.7	30,500	14.5	337,300	13.5

By March 31, 1979, the new CETA amendments will have been implemented. The reauthorization provides a strengthened focus on the employment problems of older workers. Title II (the new title for comprehensive employment and training programs) specifically provides that the Secretary of Labor shall insure that prime sponsors' plans shall provide a demographic breakout of their unemployed population, and shall provide the details of the specific services that shall be provided to individuals who are experiencing severe handicaps in obtaining employment including those who are 55 years of age and older. Title III of the new statute provides broad authority for research and demonstration programs and the establishment of employment and training policies and programs to focus on providing older workers a more equitable share of employment and training resources to reflect their importance in the labor force.

CETA—NATIONAL PROGRAMS

On April 1, 1977, the Department of Labor provided the Administration on Aging (AOA) with CETA discretionary funds to continue 15 grants for older worker employment projects which were originally authorized under title X of the Public Works and Economic Development Act. These were later funded by the Employment and Training Administration through direct grants.

During 1978 as many as 5,300 persons were employed in the program. However, the Department has encouraged a gradual reduction in the number of enrollees through a transfer of enrollees into title V of the Older Americans Act. Currently, fewer than 4,000 persons are working in the program. The remaining participants will be supported until June 30, 1979, at which time it is anticipated that most of the enrollees will be transferred into other jobs or programs.

The Employment and Training Administration has budgeted $18.6 million for this purpose.

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM (SCSEP)

The U.S. Department of Labor administers the senior community service employment program (SCSEP). This program, authorized by title V of the Older Americans Act, offers subsidized part-time employment to low-income persons aged 55 and above. Program participants work in a wide variety of community service activities and facilities, including day care centers, schools, hospitals, senior centers, and beautification, conservation, and restoration projects. In addition to subsidized community service jobs, SCSEP participants receive yearly physical examinations, personal and employment related counseling, job training, and in some cases, referral to unsubsidized jobs.

Activity under this program was, in earlier years, sponsored by a group of five national-level organizations: Green Thumb, Inc., the National Council of Senior Citizens, the National Council on the Aging, the National Retired Teachers Association-American Association of Retired Persons, and the U.S. Forest Service. Until July 1, 1977, they sponsored all local projects throughout the Nation.

During the program year of July 1976 through June 1977 the SCSEP subsidized about 15,000 jobs. Financial support for that period was provided by a $55.9 million supplemental appropriation that was made in the last quarter of fiscal year 1976.

In July 1977, the program was expanded to provide an additional 22,400 jobs for a new total of 37,400. During the 12-month period of July 1, 1977, through June 30, 1978, financial support for the program was provided by $90.6 million from the fiscal year 1977 appropriation and $59.4 million from the Economic Stimulus Appropriations Act, bringing total funding for this period to $150 million.

The fiscal year 1978 appropriation provided $200.9 million for SCSEP. These funds are sustaining the program during the period from June 1978 through July 1979. This level of funding made 10,100 new community service jobs possible, bringing the current total to 47,500.

Beginning with the $150 million appropriation for the 1977–78 program year, SCSEP funds were divided with 80 percent going to national sponsors and 20 percent going to State governments. Without regard to the sponsoring organization, however, funds are allocated so that each State receives an equitable share of the total appropriation based on the number of eligible individuals.

In addition to the five national sponsors that have historically operated SCSEP projects, the Department added three additional sponsors for the 1978–79 program year. Selected through a competitive process were the National Urban League, the National Association Pro-Spanish Speaking Elderly, and the National Center on Black Aged.

The progress report covering SCSEP activities for the program year ended June 30, 1978, is attached.

The Department's request for fiscal year 1979 is $220.6 million. This will sustain the current 47,500 SCSEP jobs during the program year that will begin July 1, 1979.

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM PERFORMANCE REPORT PROGRAM YEAR JULY 1, 1977 TO JUNE 30, 1978

I. Funding (in millions of dollars):	
Appropriation	$150
Obligated	$150
II. Enrollment levels	37,415
Authorized positions established	37,415
Unsubsidized placements	3,980
III. Summary of characteristics—persons actually enrolled as of June 30, 1978:	
Sex:	*Percent*
Male	37
Female	63
Education:	
8th grade and under	41
9–11	21
12	25
1–3 years college	9
4 years college and above	4
Veteran	9
Ethnic group:	
White	73
Black	20
Hispanic	6
American Indian/Alaskan	3
Asian/Pacific Islands	4
Economically disadvantaged	100
Age:	
55–59	24
60–64	28
65–69	27
70–74	14
75–over	7

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM PERFORMANCE REPORT PROGRAM YEAR JULY 1, 1977 TO JUNE 30, 1978—Continued

IV. Areas of community service in which participants were employed as of June 30, 1978:

Services to the general community	45
Education	11
Health/hospitals	4
Housing/rehabilitation	1
Employment assistance	1
Recreation/parks/forests	7
Environment quality	2
Public parks and transportation	5
Social services	8
Other	6
Services to the elderly	55
Project administration	6
Health and home care	6
Housing/home rehabilitation	4
Employment assistance	2
Recreation/senior citizens	8
Nutrition programs	12
Transportation	3
Outreach/referral	10
Other	4

V. Average hourly wage $2.80 as of June 30, 1978

OTHER PROGRAMS FOR OLDER WORKERS

National program for selected population segments: In September 1976, the Employment and Training Administration distributed $20 million from CETA title III among 83 CETA prime sponsors. These funds, which were awarded on a competitive basis, are being used to provide special services to certain target groups. Of the $20 million total, more than $1 million was devoted to projects for older workers. Two of these older workers projects were selected for an intensive study which resulted in the publication of booklets detailing how the projects can be replicated. These booklets were distributed to all CETA prime sponsors and can be obtained from the ETA clearinghouse.

Subscriptions: In June 1976, the Employment and Training Administration purchased a bulk 12-month subscription to the "Journal of Industrial Geronotology," now "Aging and Work," a quarterly publication of the National Council on Aging. This subscription was later extended through December 1978. Through this subscription (3,500 copies) the Employment and Training Administration provided copies of the Journal to CETA prime sponsors, the local offices of State employment security agencies, and the State and area agencies on aging. The purpose of this was to raise the level of understanding, on the part of professionals in the Employment and Training field, of older workers problems, needs, and progress

Promotion and development program: In October 1976, the Employment and Training Administration awarded a $100,000 contract to the Pre-Retirement Planning Center (based in Iowa). The center, working in conjunction with the senior community service employment program conducted by the National Retired Teachers Association-American Association of Retired Persons and with the employment security agencies of five States, trained 75 older individuals to serve in local job service offices as older worker placement specialists. The center's goal is to train and place additional older worker placement specialists in the months ahead. This particular effort has demonstrated that older workers can be particularly effective in placing their peers.

SUMMARY OF ACTIVITY OF PENSION AND WELFARE BENEFIT PROGRAMS AFFECTING AGING

Pension and welfare benefit programs (PWBP) an organization within the Department of Labor (DOL), administers title I of the Employee Retirement Income Security Act of 1974 (ERISA). The purpose of ERISA is to protect retirees who are receiving benefits from private sector pension plans and welfare plans, workers who participate in private pension and welfare plans and the beneficiaries of both retirees and active participants—to see that workers are not required to satisfy unreasonable age and service requirements before becoming eligible for pension plan participation and vesting benefits; to see that the money will be there to pay pension benefits when they are due; to see that plans and plan funds are managed prudently; to see that retirees and workers are supplied with the information needed by them regarding their plans; to see that spouses of retirees are given protection and to see that the benefits of retirees and workers are protected if the plan should terminate.

Summary of PWBP Program Activity

DOL is given the following responsibilities under ERISA:

ENFORCEMENT

PWBP is responsible for enforcing provisions of ERISA, with the greatest emphasis being placed on obtaining compliance with the fiduciary provisions. These provisions require, among other things, that plan trustees and administrators shall perform their plan duties solely in the interest of participants and beneficiaries. Investigations are conducted and where violations are found, the Secretary of Labor may take civil actions to recover plan assets or remove those persons from their positions of trust. The Secretary also may intervene on the behalf of any retirees, active plan participants or their beneficiaries who allege that a violation of fiduciary responsibilities has occurred in the management of a plan's financial affairs. Where violations are discovered, PWBP's general priorities are the following: move quickly to prevent any future loss of assets; recover assets that were lost; and where appropriate, remove the trustees responsible for the loss.

Strengthening the compliance program was the major priority for PWBP in 1978. As part of this effort, a number of program improvements were implemented in 1978 which included improving targeting methods, developing an enforcement manual, providing in-depth training, closely monitoring and directing field activities, creating task forces to investigate potential violations involving serious and widespread abuses, and providing more specific guidelines to the field regarding our voluntary compliance and litigation strategy. In addition, we developed an agreement with the Internal Revenue Service to coordinate investigations and share information. In effect, this enables each agency to expand the scope of its enforcement.

The program improvements implemented during 1978, were part of PWBP's effort to shift to an almost total emphasis on conducting fiduciary investigations, which protects and recover plan assets in the event of misuse. This is critical to insuring that funds are available to pay promised benefits from pension and welfare plans. While about half of compliance officer time had been spent on technical assistance 2 years ago, this was reduced to 24 percent by the end of 1978. As a result, 1,053 fiduciary cases were closed during this year.

REPORTING AND DISCLOSURE

1. Title I of ERISA prescribes, among other things, the contents of certain reports that administrators of benefit plans must file with the Federal Government. These include annual financial reports (Form 5500 series), descriptions of plan provisions and copies of the summary plan description, the booklet administrators must give to participants and beneficiaries which describe the plan benefits, how these benefits are earned and how these benefits may be lost.

During 1978, PWBP and the IRS initiated develoment of a compliance oriented annual report for small plans which will be filed once every 3 years, with a registration form to be submitted for every other 2 years. These returns which replace an annual filing will more effectively assist the agencies in their enforcement efforts. Also during 1978 the Department proposed a new format for the Summary Annual Report (SAR), which plans must provide participants with a snapshot of the financial condition of the plan, and indicates where further information may be obtained.

2. PWBP maintains a facility where reports submitted to the Department may be examined. Copies are available at a slight fee. Phone and mail requests

are also filed. The address is: Department of Labor, PWBP Public Disclosure Room, Room N4677, 200 Constitution Avenue N.W., Washington, D.C. 20216. The phone number is (202) 523-8773.

PUBLIC EDUCATION AND INFORMATION

The Office of Communications and Public Services (OCPS) in PWBP distributes publications describing the protections of ERISA for retirees and workers. The Office works with magazines such as "Modern Maturity" and "Dynamic Years" in providing information about benefit plans to retirees. Our staff in our network of field offices and in the national office responded in 1978 to 69,279 letters and 462,757 phone calls from benefit plan participants, beneficiaries and persons involved in the administration of the plans.

There also is a Speakers Bureau which will send specialists on various facets of benefit plans to address interested groups. The address is: Department of Labor, PWBP, OCPS, Room N4662, 200 Constitution Avenue NW., District of Columbia, 20216. The phone number is (202) 523-8921.

RESEARCH AND DEVELOPMENT

PWBP conducts a program of research concerning benefit plans which may be used for developing future legislation. During 1978, the following studies related to retirement and pension plans were initiated.

1. A contract to provide a reliable data base on selected characteristics of certain pension plans. This will be merged with social security records to create multipurpose computer file able to support a wide range of retirement income studies.
2. A study to analyze the extent to which portability and reciprocity arrangements currently exist among private sector single employer plans.
3. A study to determine just how effective private sector pension plans are in meeting the economic security needs of women.

PRESIDENT'S REORGANIZATIONAL PROPOSAL NO. 4

During 1978 final authorization was given for the President's Reorganization Plan No. 4 which realines ERISA responsibilities between the Departments of Labor and Treasury. Implementation of the Reorganization Plan began on December 31, 1978. One of the elements of this plan calls for an evaluation to be conducted during 1979 which includes an examination of alternative methods of administering ERISA. This will address the coordination of ERISA with other retirement income policies and programs.

ITEM 10. DEPARTMENT OF TRANSPORTATION

FEBRUARY 26, 1979.

DEAR MR. CHAIRMAN: In response to your letter of December 1, 1978, I am pleased to send to you the enclosed report which summarizes significant actions taken by this Department during the past year to improve transportation facilities and services for older Americans.

If we can assist you further, please let us know.

Sincerely,

BROCK ADAMS.

Enclosure.

SUMMARY OF ACTIVITIES TO IMPROVE TRANSPORTATION SERVICES FOR THE ELDERLY

INTRODUCTION

The following is a summary of the major actions taken by the U.S. Department of Transportation during 1978 to improve transportation for the elderly.[1] The information included in the report was furnished by the following operating elements of the Department: Federal Aviation Administration (FAA), Federal

---

[1] Many of the activities highlighted in this report are directed toward the handicapped. However, more than one third of the elderly are handicapped and will benefit from these activities.

Highway Administration (FHWA), Federal Railroad Administration (FRA), National Highway Traffic Safety Administration (NHTSA), Urban Mass Transportation Administration (UMTA), and Research and Special Programs Administration (RSPA).

REGULATIONS

Office of the Secretary.—On June 8, 1978 the Department of Transportation published in the Federal Register proposed rules to implement section 504 of the Rehabilitation Act of 1973, concerning transportation for the handicapped. The proposal, which will be issued in final form within the next several months, sets forth standards and timetables for making all modes of transportation more accessible to persons with handicaps.

Federal Aviation Administration.—FAA continued in 1978 to review procedural plans submitted by airlines as required by its 1977 regulations concerning the transportation of the handicapped on commercial aircraft. These regulations were designed to give the handicapped maximum access to air transportation consistent with the reasonable constraints of safety and comfort.

MONITORING OF COMPLIANCE WITH REGULATIONS

Federal Highway Administration.—The FHWA in cooperation with UMTA, continued to monitor the activities of metropolitan planning organizations to meet the "specific efforts" requirement in planning public mass transportation facilities that can effectively be used by elderly and handicapped persons.

The FHWA continued to monitor State compliance with section 402(b)(1)(f) of 23 U.S.C., which provides for curb cuts at pedestrian crosswalks, and the FHWA requirement that all new rest area facilities on Federal-aid highways be designed to accommodate handicapped persons.

POLICIES AND GUIDELINES

Federal Aviation Administration.—FAA's Flight Standards Service is working with the Air Transport Association in preparing an advisory circular which will be directed toward the development of uniform procedures among the airlines for transporting handicapped persons.

National Highway Traffic Safety Administration.—NHTSA initiated planning to modify and augment standards written by the Veterans Administration (VA) which provide performance and equipment standards for driving aids used by disabled veterans. Considerable exploratory research is planned to upgrade the present VA standard, which will also affect approximately 5 million nonveteran drivers. By specifying appropriate human engineering guidelines, a Fedeal motor vehicle safety standard (FMVSS) could add significantly to disabled driver safety.

CAPITAL ASSISTANCE

Federal Aviation Administration.—The agency issued airport development aid program grants to airport operators in the amount of $37.4 million (fiscal year 1978) for construction of terminal facilities. All such grants require assurance and certification that these facilities be designed to comply with the "American Standard Specification for Making Buildings and Facilities Accessible To, and Usable By, the Physically Handicapped."

At the Washington National and Dulles International Airports, the agency has improved the location and increased the number of parking spaces set aside for handicapped, increased the number of ramps both inside and outside the terminals, improved restroom facilities, increased the availability of wheel chairs, increased the availability of amplified telephones, and installed a TELEX system to assist the totally deaf in communicating. Plans are being developed for major renovation of restrooms, additional elevators, automatic door openers, additional ramps, etc.

Federal Highway Administration.—In 1978 all types of Federal-aid highway funds were available to provide facilities to accommodate handicapped and elderly persons on the Federal-aid systems. Under certain conditions Federal-aid funds (except interstate system funds) could also be used to provide such facilities along highway not on the Federal-aid system.

National Highway Traffic Safety Administration.—Under the State and community highway safety program of NHTSA, States are encouraged to plan and to execute their own projects to benefit the elderly. Through the use of Federal,

460

State, and local funds, States were planning, preparing, and providing programs for the elderly in the areas of driver instruction, pedestrian safety, and driver licensing.

An excellent example of these types of activities is the State of Illinois where a specific driver reeducation program for the elderly was initiated as a result of Federal assistance. The program entitled, "the senior driver improvement program," was designed to assist elderly drivers to become more knowledgeable about the driving task and ways to compensate for their driving deficiencies. A study guide and a coordinator's handbook were developed and are available from the State of Illinois. This program should prove valuable to senior drivers who wish to continue their driving in a safe and more skillful manner.

Urban Mass Transportation Administration.—During fiscal year 1978, $25 million was set aside under section 16(b)(2) of the Urban Mass Transportation Act of 1964, as amended, to provide grants to private nonprofit organizations in the acquisition of capital equipment for the provision of transportation services to the elderly and handicapped. Of the $25 million that has been set aside, grants totalling nearly $16.3 million have been awarded to 45 States.

TECHNICAL ASSISTANCE

Federal Highway Administration.—In September, the FHWA issued a technical advisory to all State transportation agencies with recommendations on the design and construction of pedestrian facilities to accommodate elderly and handicapped persons. The three areas of concern discussed in the advisory were ramps, curb treatments, and passenger loading/parking zones.

INFORMATION DISSEMINATION

Federal Aviation Administration.—The FAA, in cooperation with the Airport Operators Council International and the Architectural and Transportation Barriers Compliance Board, published the second edition and second printing of "Access Travel: Airports," a guide listing the special services available to aged or handicapped persons at 220 terminals in 27 countries. Copies of the guide may be obtained from the Consumer Information Center, Pueblo, Colo. 81009.

Federal Highway Administration.—Under FHWA's education and training information exchange program, administered by the National Highway Institute (NHI), training aids such as instructor and student guides, visual aids and reference materials developed for NHI-sponsored courses, were made available at no cost to universities and State and local transportation agencies to further disseminate the course content. In addition to materials from the courses cited below, the University of Tennessee Transportation Institute, under contract with UMTA, began to develop a series of slide tape presentations on public transportation issues, including the problems of elderly or handicapped travelers. These materials will be available through the NHI exchange program.

WORKSHOPS

Federal Aviation Administration.—As part of its ongoing training program, FAA sponsored workshops for agency and industry emergency procedures instructors. Of the 8 to 12 hours involved in these workshops, about one quarter of the time was devoted exclusively to instruction in procedures for assisting the aged and handicapped.

Federal Highway Administration.—Under the sponsorship of FHWA's National Highway Institute (NHI), two training courses were conducted in 1978 that included discussions of the transportation problems of elderly and handicapped persons.

"Public Transportation—An Element of the Urban Transportation System," co-sponsored by the UMTA, was presented at 18 locations throughout the United States to 416 participants. "Pedestrian and Bicycle Considerations in Urban Areas—An Overview" was conducted at 9 different locations and attended by 225 participants. In addition, three pilot "Design of Urban Streets" were conducted before year's end for some 90 participants. Participants in the NHI courses generally represented Federal, State, or local transportation agencies.

RESEARCH AND DEMONSTRATIONS COMPLETED

Federal Aviation Administration.—FAA initiated in 1978 corroborative studies on the evacuation of aircraft with specific emphasis on blind persons. The tests, conducted by FAA's Civil Aeromedical Institute (CAMI), considered evacuation time with and without use of canes through windows, doors, slides, and steps. CAMI evaluated, among other things, the utility of telescoping canes, the movement of unsecured canes under expected deceleration forces, and the implication of the use of canes while on evacuation chutes. A report on this study is now in preparation.

A literature search was completed in 1978 by CAMI on the effects of aging for application to both aircrew and passenger related regulatory actions and service considerations.

CAMI also established a computer data bank on the human factors aspects of aircraft accidents and incidents. Accident investigators have been alerted to the need to report specialized information concerning problems experienced by the aged and handicapped. This data base will be useful in correcting the more apparent problems quickly and some of the more subtle problems which become apparent from statistical examination over a longer period of time.

Federal Highway Administration.—The FHWA completed a study on the problems of elderly and handicapped pedestrians, which produced a manual to help local officials make their cities more accessible to these individuals.

Urban Mass Transportation Administration.—UMTA developed vehicle requirements and inspection techniques for the 10-to-16 passenger van, the most widely used paratransit vehicle in UMTA's 16(b)(2) program. The project resulted in a specification and acceptance inspection package based on the market-availability of components. The packages were forwarded to state Departments of Transportation for comment and their use if desired.

A preliminary report was submitted describing the findings of a five-man team who travelled to Stockholm, Sweden to evaluate the use of the inclined elevators in that city's rail rapid transit system. Inclined elevators travel at the same angle as the escalator, alongside the escalator, and have a capacity of 12 persons. The team reported only minor code differences between what is being used in Stockholm and what would be required for an elevator in the U.S. They found the inclined elevator used by mothers with perambulators, people with packages, wheelchair-users, as well as the elderly. The team recommended that an inclined elevator be demonstrated in this country.

RESEARCH AND DEMONSTRATIONS ONGOING

Office of the Secretary.—A project supported by the Office of Environment and Safety will produce a final report in early 1979 on the barriers to coordination of transportation services provided to clients of health and social service agencies in three U.S. cities. The report will include recommendations on how to coordinate and consolidate such services.

Federal Highway Administration.—The FHWA Office of Research initiated several research studies on the accommodation of elderly and handicapped people on pedestrian over- and undercrossing stuctures. These studies seek to identify the problems and hazards confronting pedestrians with special needs and to recommend effective facility design treatments or alternative solutions.

In addition, a pedestrian safety demonstration project to implement and evaluate at least three safety strategies continued in the Commonwealth of Puerto Rico. These improvements will also enhance the safety of elderly pedestrians.

Federal Railroad Administration.—FRA developed a proposal to study how foreign railroads provide transportation services for handicapped passengers. If special provisions made by foreign railroads can be easily adapted by American railroads, the study will recommend their implementation in the northeast corridor.

National Highway Traffic Safety Administration.—An ongoing study to be completed early in 1979 identified vehicle design deficiencies reported by disabled drivers. The results will be used to support future motor vehicle safety standards and will establish priorities for future research.

NHTSA initiated a 2-year study to determine what types of performance and design requirements are needed to improve the safety of special adaptive driving aids needed by disabled drivers.

Another ongoing contract was awarded to identify driver licensing and improvement requirements of older drivers. Currently, an information package is being developed to help the elderly compensate for their driving difficulties.

NHTSA began planning a project in cooperation with the National Retired Teachers Association and the American Association of Retired Persons to define the driving problems of the elderly and to evaluate a voluntary elderly driver retraining program. The objective of the training program will be to compensate for, or remedy, the performance decrements of individuals over 55 years of age.

Urban Mass Transportation Administration.—Three planning research projects were initiated in 1978 by UMTA's Office of Transit Planning. These three studies are entitled (1) "Planning for the Phase in of Transbus," (2) "Elderly and Handicapped Transportation Data Collection," and (3) "Analysis of Elderly and Handicapped Transportation Services."

A demonstration in Allegheny County Pa. (Pittsburgh Metropolitan Area), was begun to provide the first large scale test of the "transportation broker" concept for providing paratransit service to the elderly and handicapped persons. Through a paratransit agent-broker, social service agencies and individual elderly and handicapped consumers have the ability to purchase service on a coordinated paratransit system at ride-sharing rates. Local private operators, through contracts with the agent brokers, are the service providers.

UMTA provided another demonstration grant for the purchase of transit vehicles for the Navajo Indian Reservation to enable the Tribe to establish a bus system on the reservation. The system will be geared particularly to the health care needs of elderly and handicapped persons on the reservation.

Two reports were released this year as a product of a major UMTA-supported research effort on the transportation problems of transportation handicapped persons. These reports, entitled "Summary Report" and "Technical Report of Data from National Survey of Transportation Handicapped People," showed that 47 percent of the transportation handicapped population living in urban areas is 65 or over.

Another UMTA research effort in 1978 was a review of the state-of-the-art of wheelchair lifts for standard buses to determine the maturity of lift technology, the production capability of lift manufacturers, and the experiences with lifts at transit properties. The conclusion was reached that it is technically feasible to produce a reliable lift, but whether a suitable one is available remains a question.

The California Department of Transportation began to install four different lift designs into existing transit buses at four transit properties. Each lift will be evaluated in a controlled transit service. Lifts were selected for this project through a design competition.

The California Department of Transportation (Caltrans) also carried out a project aimed at improving lifts and securement systems for wheelchairs on transit vehicles. Safety guidelines for lifts were developed with the aid of a project advisory panel composed of rehabilitation engineers, lift designers, lift manufacturers, representatives of the California Highway Patrol, and the chief engineer of a major wheelchair manufacturer. The safety guidelines are being reviewed and will be published and distributed during 1979. As another part of this project, Caltrans built and crash-tested five securement systems similar in design to those on the market today, using standard wheelchairs both facing and perpendicular to the direction of travel. The study showed how the wheelchair behaves under emergency conditions when held by the different fastening systems, and where best to attach the securement system to the wheelchair. To date about 40 tests have been run, at 5 and 10 g's. Further tests will be conducted during 1979.

Caltrans also field-tested normal bus operating conditions and emergency stops (not crashes) with a rider in a wheelchair and with the wheelchair brakes locked, but with no additional securement system. A movie was made showing the effect of quick stops and starts and turns. The movie demonstrated that the wheelchair-user was indeed in a hazardous situation without devices in addition to wheelchair brakes to hold him or her stationary.

A mock-up of the front end of a typical Transbus was built in order to obtain more refined information on the ramped-entry design. Over 50 people with transportation-related handicaps participated in the research. Areas of study included ramp surfaces, edging, potential benefits of handrails on the ramp, and the discontinuity between the ramp and the bus floor. An important question addressed by this research was whether it is possible to make a direct transfer of GSA standards for buildings to transportation facilities and vehicles. A report will be published in March 1979 compiling the data on the test subjects, their demonstrated abilities, and correlations between what measurements can be expected and what the test subjects were able to do.

UMTA joined the National Highway Traffic Safety Administration (NHTSA) in an ongoing project to design, develop, test, and demonstrate a seating-protection system that protects handicapped passengers in transit and school buses, in wheelchairs and not in wheelchairs, side-facing and forward-facing. NHTSA will be crashing four sizes of school buses (several of which are also sold as transit vehicles) and two large transit buses. The purpose is to obtain crash-pulses to learn what forces the bus and the passenger (anthropomorphic dummy) experience during a crash. Output of this project will be one or perhaps several crash-protection designs and a full-scale engineering mockup demonstrating how a handicapped passenger can be protected.

In 1978, UMTA initiated a project to develop an operational front door ramp that meets the production model Transbus specification. Feasibility of a ramp was demonstrated in the experimental Flexible Transbus; however, the dimensions of the Transbus specification are different from the prototype vehicle. The ramp will also be tested and results will be passed on to Transbus manufacturers to help them develop their own ramp. The objective is to put the ramp through first-generation development before Transbus manufacturers start their ramp development efforts.

UMTA awarded a contract to design, fabricate, and test an escalator-modification kit, to be applied to existing escalators, that would make the escalator accessible to the wheelchair-user and other handicapped travelers.

In 1978, Congress appropriated funds to continue the UMTA paratransit vehicle program. The goal of the current paratransit development program is to produce a product that will sell at a reasonable price and that can be easily serviced and maintained. By late 1979 UMTA expects to have mockups of paratransit vehicles from up to three contractors, and by 1980 three prototypes per contract.

Research and Special Programs Administration.—The Office of University Research supported two ongoing projects relating to transportation for the elderly. Shaw University in Raleigh, N.C., was awarded a contract to investigate the use of school buses for transporting elderly and non-student, non-wheelchair handicapped persons during off-peak hours, including the legal and institutional barriers to such use. In the second project, the Transportation Training and Research Center of the Polytechnic Institute of New York is nearing completion of a study to develop a methodology for evaluating existing and new transportation services with respect to meeting the travel needs of the elderly and handicapped, and to develop suggested service standards for different types of handicaps.

ITEM 11. DEPARTMENT OF THE TREASURY

JANUARY 11, 1979.

DEAR MR. CHAIRMAN: On behalf of the Secretary of the Treasury, I am furnishing you with a summary of Treasury activities benefiting the elderly during 1978. You may be assured that efforts will be continued during 1979 to improve our programs to facilitate the elderly.

You will note that our submission (attached) is comprised of material furnished by Treasury bureaus and offices.

If we can provide additional assistance to the committee, please contact us.

With kind regards,

Sincerely,

WALTER J. MCDONALD,
Acting Assistant Secretary (Administration).

Enclosures.

INTERNAL REVENUE SERVICE ACTIVITIES AFFECTING THE AGED

Persons aged 65 and over comprise a significant segment of the general population and the Internal Revenue Service places considerable emphasis on informing these people of their tax rights and responsibilities, a number of which apply only to this group. The IRS also continues to make a special effort to inform older

Americans who because of immobility, impaired health or any of several other factors, may miss out on some tax benefits to which they are entitled unless IRS reaches them directly. The Service recognizes that, as is the case with many social programs, the people most likely to miss out on the benefits are those with the greatest need for them.

During calendar year 1978, the Service issued a number of informational materials geared toward taxpayers age 65 and older. Those materials focused on the following themes:

—Tax benefits common to all taxpayers 65 and older, including the extra personal exemption and extra general tax credit.

—Reducing the income tax of older Americans through the tax credit for the elderly, available to many in this age group.

—Older Americans can be eligible to exclude up to $35,000 of the gain on the sale of their principal residence.[*]

—Single taxpayers 65 and older can receive up to $3,700 in income before being required to file a tax return. (The limit for singles younger than 65 is $2,950.) When at least one of the spouses of a married couple is 65 or older, the filing requirement is set at a higher income than when neither spouse is that old. This primary tax benefit for the elderly, like the extra personal exemption, has been communicated throughout the country.

—The nontaxability of social security payments, railroad retirement benefits, and other benefits from a general welfare fund, such as payments for blindness.

—For retirees receiving pensions which are taxable, IRS has publicized the existence and usefulness of Form W-4P, which authorizes the payor of the pension to withhold taxes at the source to avoid an unexpected tax bill for the retiree at the end of the tax year.

—The necessity for part-time workers, many of whom are 65 and over, to file for a refund if there was any money withheld from their pay during the year, even though their income failed to meet the minimum filing requirement.

—The various services provided by the IRS-sanctioned volunteer income tax assistance (VITA), a tax aide volunteer program designed to assist taxpayers who for one reason or another will not or cannot visit an IRS office for help with their return. Because of limited mobility this group includes a disproportionately large number of older Americans.

—The services offered older Americans by IRS taxpayer service personnel: Free telephone assistance, walk-in service at IRS offices, free tax information by mail and temporary offices operating during the filing season.

To communicate the information in 1978, the Internal Revenue Service issued: One filmed television public service announcement (PSA); one recorded radio PSA; one filmed 4-minute television program aide (TPA); two recorded radio interview programs (2 to 4 minutes long); several live-copy radio PSA scripts to be read on the air by local announcers; one 4-minute live-copy radio program script, and various materials prepared for the print media. These are comprised of news releases, feature articles, fact sheets, featurettes, question and answer columns and informational illustrations with captions. Items were reproduced by daily and weekly newspapers, magazines and newsletters across the Nation. Moreover, a newspaper supplement, including a feature on tax considerations for older Americans, was prepared and distributed to newspaper editors.

Following are additional activities in which we engaged during calendar year 1978 which would benefit elderly taxpayers:

—We tested Schedules R & RP, Credit for the elderly, as a part of the overall 1040 tests last summer. We believe we have made considerable progress in redesigning the schedules to make them easier to prepare and in clarifying the instructions for the schedules to make them easier to understand. Further, we would like to point out that our 1978 Instructions offer to compute the credit for the elderly as well as the tax.

—Special training on Credit for the Elderly, Schedule R, pensions and annuities and other issues affecting the elderly were provided for employees who performed tax assistance work during the 1978 filing period.

---

[*] For sales after July 26, 1978, individuals 55 and over are allowed a one-time exclusion of up to $100,000. This provision of the Revenue Act of 1978 was highlighted in the 1978 tax package and appropriate IRS publications, including Pub. 554, Tax Benefits for Older Americans (see below), were also updated to reflect this change.

—Expanded by nearly 50 percent the assistance to older Americans and other taxpayers through the volunteer income tax assistance (VITA) program. Training for VITA volunteer assistors emphasized tax problems of the elderly. Special lessons geared to the tax situation of older citizens included information on tax credits for the elderly, estimated tax payments and Form W-4P.

—In conjunction with the National Retired Teachers Association and the American Association of Retired Persons, workshops were conducted for senior citizen managers of tax aid/VITA programs. These volunteer managers, in turn recruited and trained other volunteer assisters an instructors in the tax aide/VITA program for the elderly.

—We continued conducting "retiree income tax seminars" as part of our overseas taxpayer assistance program. These seminars are designed to assist retirees and senior citizens residing abroad to determine their correct U.S. tax obligations. The seminars consist of discussions of tax laws and forms applicable to this particular taxpaying group. The discussions are followed by an exercise in the preparation of a tax return under the guidance and assistance of a tax assister.

—Emphasis was placed on securing first floor space or, alternatively, easy access to elevators as an aid to handicapped and senior citizens was continued.

—Emphasis was placed on the protection of retirement benefits for both rank and file employees and retirees.

—Assistance was provided by our actuaries in answering questions relating to retirement programs and tax benefits available.

—During 1978, temporary regulations were issued to provide guidance to retired persons relating to the exclusion from income of certain disability payments.

—In 1978 we published the following revenue rulings affecting senior citizens:

(1) Rev. Rul. 78-99, 1978-1 C.B. 152, held that an organization providing individual and group counseling to widows to assist them in legal, financial, and emotional problems caused by the death of their husbands and providing them with information on available benefits and services qualified for exemption under section 501(c)(3) of the Code.

(2) Rev. Rul. 78-435, 1978-51 I.R.B. 9, held that the sale of hearing aids to its patients by an exempt hospital whose primary activity is rehabilitating the handicapped, including those with hearing deficiencies, does not constitute an unrelated trade or business under section 513 of the Code.

(3) Rev. Rul. 78-170, 1978-1, I.R.B. 24, provides that payments made under the laws of the State of Ohio to qualified individuals to reduce their cost of winter energy consumption are not includible in gross income. In order to qualify for these credits an individual must (1) be a head of household, (2) be at least 65 years old or be totally and permanently disabled, and (3) have a total income of not more than $7,000.

(4) Rev. Rul. 78-263, 1978-27, I.R.B. 11, provides that payments made by a company under a deferred compensation plan which does not specify a retirement age, to an officer retired at age 60 who is also covered by a qualified pension plan allowing retirement at age 65, are not excepted from wages under sections 3121(a)(13) and 3306(b)(10) of the Code. This is true even if the company has a separate qualified pension plan for nonsalaried employees allowing retirement at age 60. Such payments made to an officer reaching age 65 also will not be excepted from wages.

—In addition, we updated and published the following publications that deal with tax issues of particular interest to the elderly: Publication 524, Tax Credit for the Elderly; Publication 554, Tax Benefits for Older Americans; Publication 559, Federal Tax Guide for Survivors, Executors and Administrator; Publication 567, Tax Information on U.S. Civil Service Retirement and Disability Retirement; and Publication 575, Tax Information on Pension and Annuity Income. Publication 523, Tax Information on Selling or Purchasing your Home, has a section, specifically dealing with the capital gains exclusion on sale of a residence for taxpayers over 55.

All of these publications are available free of charge at IRS offices. They are also used extensively in taxpayer education programs, often in cooperation with organizations especially interested in problems of retired people. Our public information plans for 1979 include the following:

- —Continuing the comprehensive information program for older Americans employing both the electronic and print media. Three recorded radio PSA's; one film television PSA; one recorded and one live-copy interview program; three live copy radio PSA scripts.
- —As for the print media, we plan to issue a broad range of written items, to include a special package of information for distribution across the United States to publications serving older Americans. Provisions of the Revenue Act of 1978 on, for example, the new $100,000 exclusion for sale of personal residence will be emphasized. By combining the exposure of tax information for senior citizens in publications devoted to this group, along with periodicals for general audiences that include older readers, such as daily and weekly newspapers, we hope to expand the opportunities for these taxpayers to learn about the tax benefits designed especially for them.

During 1979, we also plan to:

- —Continue to provide special training in elderly issues for employees who perform tax assistance work during the 1979 filing period.
- —Expand technical support and training for VITA volunteers on tax issues affecting older citizens as authorized by the Revenue Act of 1978.
- —Improve the overall quality and management of the VITA program and to continue to promote program growth.
- —Schedule workshops for the National Retired Teachers Association and the American Association of Retired Persons volunteers. This workshop will be similar to those conducted in 1977 and 1978.
- —Continue to conduct seminars to assist citizens residing abroad with their U.S. tax obligations.
- —Continue computer preparation of Forms 1040A test.
- —Within the framework of existing law, we will continue our efforts to simplify all tax forms, instructions and schedules impacting on the elderly.

In addition, due to recent legislative changes, some taxpayers who had retirement income during 1977 which qualified as community property income may have been entitled to a larger credit than they originally claimed on their 1977 Schedule RP. We plan to advise all taxpayers who filed a 1977 Schedule RP that they should review their credit computation to insure that they took the full credit benefit to which they are entitled.

BUREAU OF GOVERNMENT FINANCIAL OPERATIONS ACTIVITIES AFFECTING THE AGED

Treasury's direct deposit program for Federal recurring payments, which was implemented in 1975, was expanded to include recipients of civil service and railroad retirement annuities during 1976 and recipients of Veterans Administration compensation and pension in 1977. The program allows the recipients of Federal recurring payments to have their monthly payments delivered directly to the financial organization of their choice for deposit to personal checking or savings account. As of December 1, 1978, over 9.2 million recipients have enrolled in the program. Since 1977, a nationwide marketing campaign has been underway to inform more elderly recipients about the advantages of the program.

BUREAU OF THE MINT ACTIVITIES AFFECTING THE AGED

The Bureau of the Mint, although not involved in programs specifically designed to provide services to the aged, has emphasized in our affirmative action plans and in all special emphasis programs and hiring practices that age will not be a limiting factor in selection practices.

The bureau has initiated a preretirement planning seminar program. The first seminar was conducted in the Philadelphia Mint facility in October 1978. The opportunity to participate in preretirement planning seminars will be extended throughout the Mint during fiscal year 1979.

OFFICE OF THE SECRETARY, ASSISTANT SECRETARY (ADMINISTRATION) ACTIVITIES AFFECTING THE AGED

The equal employment opportunity affirmative action plan for fiscal year 1979 reaffirms Treasury policy that there must be equal opportunity provided without regard to age.

In 1978, an all-day occupational health seminar was held for first-line supervisors, safety officers, personnelists, and other Treasury management and administrative staff personnel. One of the four topics on the agenda was "Health Problems of Aging—An Approach to Good Physical and Mental Health." The purpose of this presentation, by an associate professor at a local medical school (who is also a recognized geriatrician), was to increase awareness that problems of aging can be minimized.

U.S. SECRET SERVICE ACTIVITIES AFFECTING THE AGED

During the fiscal year 1978, the Secretary Service closed 41,245 social security check forgery cases and 13,012 supplemental security income forgery cases. Most of these were checks issued to retirees. The identity of the forger was discovered in approximately 60 percent of the cases.

U.S. CUSTOMS SERVICE ACTIVITIES AFFECTING THE AGED

The U.S. Customs Service, in coordination with the Department of Commerce, participates in the U.S. Travel Service's "port receptionist program." Port receptionists are located within the boundaries of the Customs facility at many major airports and are available to provide necessary services (wheelchair, etc.), to the elderly and the infirmed. When Customs is notified by the U.S. Travel Service that an elderly or infirmed traveller is arriving, Customs makes every effort to facilitate the traveller's clearance through Customs. The port receptionists are, in most cases, bilingual and can provide assistance to both U.S. citizens and foreign travellers who are elderly or infirmed.

At all border stations, the U.S. Customs Service, under current OSHA regulations, insures that all new border stations or architectural modifications to present stations, include ramps, stability bars in rest rooms, etc., to insure that Customs facilities are accessible to and usable by all individuals including the handicapped, disabled, elderly and infirmed.

OFFICE OF THE COMPTROLLER OF THE CURRENCY ACTIVITIES AFFECTING THE AGED

The Office of the Comptroller of the Currenry (OCC) is responsible for assuring compliance of the Nation's 4,700 national banks with the Equal Credit Opportunity Act (ECOA). A major provision of this law is the prohibition of discrimination on the basis of age in granting credit.

The Comptroller's Office enforces this prohibition as part of regular examinations of national banks for compliance with consumer protection laws. The examination process includes a review of the bank's written loan policies and procedural manuals for indications of possible discriminatory practices, and for violations of the law, in addition to a general audit conducted of the bank's loan portfolio.

As a supplement to the regular examination process, the OCC is seeking to identify discriminatory practices by banks through the development of a new data analysis system. Age is one of the variables which will be included in this project.

In addition to enforcement of the EOCA, the Comptroller's Office engages in a number of other activities which help to promote lending by national banks to the elderly, as part of its overall functions in consumer and civil rights. For example, OCC disseminates information educating consumers on how to obtain credit, and acquainting them with their rights under the law. During 1978, OCC distributed to all national banks a consumer complaint pamphlet which outlines the procedures a consumer should follow in filing a complaint, and includes a preprinted complaint form together with an addressed, franked envelope in which to submit the complaint.

Another bureau function with substantial, although indirect, benefits to the elderly is an increasing effort to facilitate lending in older urban areas, many of which contain disproportionately large populations of elderly citizens. The OCC is encouraging banks to lend in such older neighborhoods through enforcement of the Community Reinvestment Act, and through special programs such as the Interagency Commercial Reinvestment Task Force, which is developing a pilot program for urban neighborhood commercial revitalization.

The OCC has recently created a special Office of Customer and Community Programs. The establishment of this new office will substantially strengthen the bureau's activities in consumer affairs, civil rights, and community development, all of which will tend to benefit elderly users of bank credit.

The Comptroller of the Currency serves as a member of the Board of Directors of the Urban Reinvestment Task Force. A principal programs of this force has been the Neighborhood Housing Services. This program seeks to revive the flow of private capital into declining urban neighborhoods. The elderly should greatly benefit from the successful continuation of this program as they are assumed to constitute a substantial portion of the residents in such neighborhoods.

OFFICE OF REVENUE SHARING ACTIVITIES AFFECTING THE AGED

GENERAL REVENUE SHARING PROVISIONS AFFECTING THE AGED

The general revenue sharing program is a direct general fiscal assistance program that provide funds to State and local governments. No application other than a statement of assurance is required of State and local jurisdictions to receive these monies, therefore the GRS is described best as an "entitlement" program.

Congress created the program in 1972 with the intent of sharing the progressive Federal income tax with State and local governments. Legislative provisions of the program indicate an intent to disburse these funds with minimum restrictions on use and maximum attention to permitting control by the local decisionmakers to determine how they could spend the money.

The State and Local Fiscal Assisstance Act of 1972 (P.L. 92-512) was authorized for a period of 5 years to end in December 1976. However, the program was extended under the 1976 amendments (P.L. 94-488) through September 30, 1980. For the two respective periods, $55.8 billion will be distributed to State and local jurisdictions based on a statutorily prescribed formula.

Originally, State and local governments had to use the funds for priority use categories contained in the act. Under the 1976 amendments, the funds may be used for any purpose which is a legal use of the jurisdiction's own funds under State and local law. Thus recipients are to this extent free to use shared revenues for expenditures of benefit to the aged.

Extension of the program brought a number of substantive changes from the original act. Among these changes were several which could be viewed as affecting elderly persons. These amendments:

- Strengthened the nondiscrimination requirements to include specific protection against age discrimination. Originally, this provision was not to become effective until January 1979.
- Mandated special statutory public participation requirements relative to the participation of citizens in the decisions on expenditure of GRS funds and encouraged recipient governments to include senior citizens in the public participation process.[1]
- Repealed the provisions restricting the use of funds to certain priority expenditure categories.[2]
- Eliminated the prohibition of using revenue sharing funds as local matching money for other federal grants.

Measuring the impact of the changes cited above is difficult. Yet, recently available studies initiated by the Office of Revenue Sharing along with the actual use reports (AUR) submitted by recipients give us some indication of traceable benefits.[3] Results of a study conducted by Peat Marwick, Mitchell and Co. (PMM & Co.) between July and September 1978 of 40 State and local jurisdictions whose combined entitlement payments exceeded 12 percent of the total payments made to the universe of 39,000 recipient governments revealed the following with respect to two of the 1976 provisions—nondiscrimination and public participation.

Peat, Marwick, Mitchell Findings

With respect to these areas, Peat, Marwick and Mitchell found that the strengthened nondiscrimination requirements are basically perceived as being exclusively applicable to race, color, ethnic or minority groups. Awareness of handicapped status, age, and religion as integral parts of this category is still lacking.[4] They also found that of the various revenue sharing compliance requirements mandated reporting and public participation requirements were the best understood and used by recipient governments; and that under these requirements, there have been some changes in service delivery to protected classes (the aged/handicapped). Two examples of these findings are:

---

[1] 31 CFR, subtitle B, part 51, section 51.16 encourages all governments to provide senior citizens and their representative organizations with an opportunity to be heard so that their views may be considered when planning the budget.

[2] One of the eight priority spending categories under the old act (1972) was social services for the poor and aged.

[3] These reports on actual use are submitted to the Bureau of Census (under an agreement with the Secretary of the Treasury) by recipient governments. Recipient governments report on how general revenue sharing funds were used during their fiscal year by certain functional categories through the use reports. Data from the actual use reports do not fully reflect the impact of GRS since the displacement effects of the program are not completely accounted for.

Example 1.—In a large midwestern city, additional GRS funds over the amount originally budgeted for improving the city's public transit were appropriated when a public interest group representing the handicapped and elderly advised the city officials of their intentions to file a complaint with ORS if the transit vehicles were not modified to accommodate the handicapped and vehicle routes changed to better serve sections of the city with concentrations of the elderly.[5]

Example 2.—The City of Richmond, Va., attracted a sizeable group of the elderly by circulating notices through its Commission on Elderly.[6]

Other findings from the study of 40 jurisdictions which provide some indication of the effect of the GRS compliance requirements on the aged are depicted in the findings cited below relative to service delivery.

Effect of GRS on Service Delivery[7]

Principal GRS protected groups:	*Instances of service delivery*
Racial minorities	3
Handicapped	2
Elderly	1
Women	0

NOTE.—Number of jurisdictions involved: 5.

Other Probable Indicators of GRS Impact on the Aged

Efforts to measure impact on the aged requirements repealed by the amended act—priority spending categories and GRS fund usage as matching money, are discussed below. Primary data sources are the actual use reports and information from the GRS renewal hearings of 1976.

The actual use reports collected by the Bureau of Census provide data for assessing some change, if any, through governments' reports of expenditures in the category of public welfare.[8] This is what the AUR's show for the period 1975-77.

REPORTED EXPENDITURES FOR THE AGED [1]

Period	Public Law	Total expenditure for social services (in millions)	Total spent, all governments (in billions)	Percent of total GRS expenditure
1975-76 (EP 6)	92-512	170.9	$6,955	3.0
1976-77 (EP 7)	92-512	165.7	6,555	2.5
1977-78	94-488	(2)	(2)	(2)

[1] Reported use of general revenue sharing funds (AUR). Data for 1977-78 available in August 1979.
[2] Not available.

Note. EP 7 was a 6-mo. period, and EP 8 was a 9-mo. period to help aline the program with the new Federal fiscal year (October to September). Subsequent EP's are 12-mo. periods.

The successful effort in 1976 to remove the prohibition in the GRS act against using GRS funds as matching money for other Federal grants, was partly based on the contention that it caused recipients to avoid social expenditures for the poor and aged for which Federal matching aid is available. It was thought that removal of the restriction would increase the availability of funds for use in the social services area, if the jurisdiction decides to do so. The current authority of recipient governments to match other Federal funds with GRS funds has not to date been measured.

---

[4] Peat, Marwick, Mitchell & Co., final report, "*An Analysis of the Impact of General Revenue Sharing Compliance Requirements,*" chapter four, p. 8 (November 1978).

[5] *Ibid.*, chapter 4, p. 9.

[6] *Ibid.*, chapter 5, p. 2.

[7] The accomplishments of the handicapped and elderly must be combined to equal the level of changes effected by the class of racial minorities.

[8] The expenditures under the functional budgetary category of public welfare is the current classification where expenditures of benefit to the elderly would be found which replaces the social services for poor and aged category in the earlier actual use reports. Expenditures for public assistance programs including administration costs, vendor payments, medical, hospital, and nursing home care provided the needy are included under public welfare. Amounts paid from State/Federal grants for welfare purposes are also included in this category (per U.S. Bureau of Census definitions).

GRS contributions to aged Americans are likely to be visible in the results of its compresensive compliance effort . . . particularly in the areas of public participation and nondiscrimination. Future activities planned in these areas which may enhance the accessibility and accountability of units of government to the aged as a special class are:

—Publication of the age discrimination regulations during the fall of 1979.[9]

—Publication no later than January 1979 of the interim regulations with respect to a qualified handicapped individual. These regulations are amendments to the current interim nondiscrimination regulations which address service delivery, employment, and accessibility of programs to the handicapped.[10]

The Office of Revenue Sharing continues to conduct outreach activities to groups requesting assistance in program interpretation. This office also follows up on all complaints filed with it.

ITEM 12. ACTION

DEAR SENATOR CHILES: Thank you for the opportunity to provide information on ACTION's programs relating to aging for the Senate Special Committee on Aging annual report, "Developments in Aging."

ACTION's three older American volunteer programs, respectively entitled the retired senior volunteer program (RSVP), the foster grandparent program (FGP), and the senior companion program (SCP), provide opportunities for older Americans to help meet the needs of their communities across the Nation. In the 7 years of ACTION's stewardship of these programs their heathy growth in volunteer strength demonstrates their continuing worth and popularity:

RSVP from 1,816 in 1972 to 250,000 in fiscal year 1979.
FGP from 4,221 in 1971 to 16,654 in fiscal year 1979.
SCP from 900 in 1975 to 3,000 in fiscal year 1979.

The following statistics indicate the number and percentage of those 55 years of age and over who are serving in some other ACTION programs in 1978:

Name of program	Volunteers 55 years or older	Percentage of volunteers in program
Volunteers in Service to America (VISTA)	612	14.0
ACTION education program (AEP)[1]	48	6.0
Peace Corps[2]	300	4.7

[1] These programs are for students and consequently would only rarely enlist as volunteers those beyond the normal school age.

[2] A substantial percentage of those serving Peace Corps are in the age group 51 to 60.

It is also important to note that many recipients of ACTION's volunteer services are elderly. For example, Volunteers in Service to America (VISTA) estimates that approximately 20 percent of all VISTA Volunteers work in antipoverty projects geared specifically toward services to older people.

In response to the committee, I am pleased to enclose a statement summarizing ACTION's major older American volunteer activities during the course of the past year.

Sincerely,

JOHN LEWIS,
Associate Director for
Domestic and Antipoverty Operations.

Enclosure.

---

[9] The Age Discrimination Act of 1975 prohibited discrimination in the provision of services, but not employment, on the basis of age and was to be effective January 1, 1979. The act, as amended, continues to include all programs and activities receiving Federal funds and applies to persons of all ages. Two major changes are effective in the amended act (Public Law 95-478)—the repeal of the "unreasonable" age discrimination requirement, and the extension of the effective date of the regulations from January 1, 1979 to July 1979.

[10] These amendments are required to implement the Rehabilitation Act of 1973 (section 504) as amended. The ORS interim regulations become effective 60 days after publication.

FOSTER GRANDPARENT PROGRAM (FGP)

The foster grandparent program (FGP) enables low-income persons aged 60 or over to remain active in their community through person-to-person service to children with special or exceptional needs in health, education, welfare, and related settings. The foster grandparents derive a renewed sense of dignity and self-worth from their special service roles and they are provided a modest tax-free stipend to offset the costs of volunteering. They receive additional tangible benefits in the form of transportation to and from their volunteer station, a noon meal on the days (5 days per week) they serve, accident and liability insurance, and an annual physical examination.

Foster grandparents give personal attention and warm affection to the children to whom they are assigned. Ideally, the volunteers spend 2 hours with each of two children on a daily basis. Some group settings are not permissive of a strict one-on-one assignment basis. In these cases, foster grandparents may serve several children as long as the setting is conducive to the establishment of person-to-person relationships among the volunteers and the children they serve. The program provides social, psychological, and educational benefits to children with developmental disabilities and related special needs. The foster grandparents simultaneously benefit from alleviation of some of the consequences of poverty and loneliness. Their psychological outlook and physical health are improved. The mutually benefiting relationship also has a notably positive effect on the children's development and the outlook of their family.

The program provides a degree of protection of human rights of both "grandparent" and "grandchild," insuring that each group is dealt with fairly and humanely.

Children are assigned foster grandparents on the basis of their potential for improvement in personal or social adjustment, skill development and for deinstitutionalization. In the latter case, foster grandparents will follow deinstitutionalized children needing continuing attention to their own homes. Initial assignments of foster grandparents are also made in cases where they can have the greatest impact in the delay or prevention of institutionalization of children living in a home environment.

Foster grandparents are provided orientation prior to assignment to individual children. Subsequently they are provided monthly in-service training. They function as stipended volunteers and are not in the regular work force. Their activities are limited to those which would not otherwise supplant the hiring of or result in the displacement of employed workers, or impair existing contracts for service. Foster grandparents may not provide physical therapy, babysitting service, housecleaning service or other services normally performed by volunteer station staff to the children they serve. Foster grandparents are expected to accept supervision of volunteer station and project staff. Appropriate volunteer grievance and appeal procedures are the responsibility of individual project sponsors.

Foster grandparent program categorical grants are approved by the respective ACTION State program directors and awarded by regional grants and contracts officers. Grant applications for Federal funds in the amount of $250,000 or greater require headquarters review and approval. Sponsoring organizations (public or private not-for-profit agencies) provide 10 percent or more of total project costs, all or part of which may be waived at the discretion of the Director of ACTION. One of the criteria for grant approval is that volunteer benefits must be an amount equal to at least 80 percent of the Federal contribution to the project budget.

Project staff are employees of the project sponsor; they are not employees of the Federal Government. ACTION requires concurrence in the selection of project directors.

The project director, on behalf of the sponsor, recruits, trains and exercises general supervision over the volunteers. This person also develops memoranda of understanding with volunteer stations where volunteers are to be placed. He/she also ensures that foster grandparents are assigned to children with demonstrated special needs.

Project sponsors, in accepting ACTION grants to operate foster grandparent projects, agree to abide with Agency regulations and policies. ACTION, in turn, provides training and technical assistance to sponsors and project staff, and promotes cooperation and coordination with other Federal, State, and local entities concerned with the needs of low-income elderly and children with special needs, including transportation needs.

The foster grandparent program addresses the most pressing basic human needs, both in seeking the poorest of the poor to serve as foster grandparents, and in the selection of individual children the volunteers serve, recognizing that both have special needs and that some of the children served are, in many ways, less fortunate than the elderly volunteers.

The enabling legislation for the foster grandparent program is Public Law 93-113, the Domestic Volunteer Service Act of 1973, as amended.

The fiscal year 1978 appropriation for the foster grandparent program was $34.9 million. The program has grown to a strength of 16,640 foster grandparents serving more than 41,500 children. There are now 190 projects with at least one project in each State, Puerto Rico, the Virgin Islands, and the District of Columbia.

The following examples demonstrate some of the ways in which the special children served by foster grandparents benefit from the tender care, love, and patience shown them by the elderly volunteers. Five young residents of a State mental institution progressed to levels that permitted them to move into private apartments adjacent to the institution. A 12-year-old deaf child, after 4 years of rewarding relationship with a foster grandparent, improved his communication skills sufficiently that he, too, was able to move from an institution to private residence. A little girl with slow motor skills was taught by a foster grandparent to utilize a virtually useless hand through an exercise of squeezing a rag doll. She is now in school with other normal children, having achieved the priceless ability to write with the formerly useless hand. In another case where a foster grandparent was assigned to a child diagnosed as "failure to thrive," the 4-year-old child learned to speak and is now in a public school kindergarten. A bonus effect in this case is that the formerly depressed mother of the 4-year-old has become a member of the FGP project's advisory council and is now making contribution of her own to the program. The long-term effects of foster grandparental care are evident in a correctional institution when released youthful offenders return, sometimes from distant locations, to introduce a wife, parent, or girl friend to their foster grandparents.

SENIOR COMPANION PROGRAM (SCP)

The senior companion program provides meaningful opportunities for low-income persons age 60 and over, to offer person-to-person supportive services to adults, especially older persons, living in their own homes and in residential and nonresidential group care facilities.

The senior companion program, an older American community services program, was originally authorized under title VI, part V, of the Older Americans Comprehensive Services Amendments of 1973. Current authorizing legislation is title II, part B, of Public Law 93-113, the Domestic Volunteer Services Act of 1973, as amended.

The senior companion program, like the foster grandparent program, is available to low-income older persons. It provides them with opportunities through volunteer service to maintain a sense of self-worth, retain physical and mental alertness, and enrich social contacts. Additionally, the provision of a stipend and other direct benefits enables them to serve without cost to themselves.

ACTION grants to support the operation of senior companion projects are awarded to public and private nonprofit agencies and organizations. Volunteer stations where senior companions serve include hospitals, nursing home, intermediate care facilities or homes for the aged, and various health, welfare, or related settings. Approximately 70 percent of the senior companions are assigned to assist others, especially older persons, to remain in their own homes or familiar surroundings.

Senior companions serve [illegible] hours a day, 5 days a week, and receive a small stipend for their service. They are also reimbursed for transportation and provided with a meal, where possible, during orientation and on days when service is rendered. They are covered by accident and liability insurance and receive annual physical examinations. An orientation and in-service instruction program is provided, and through the project staff, senior companions receive counseling on personal matters, as well as information and referral services.

The senior companion program, first operational in 1974, has grown from 18 pilot projects and 1,000 senior companions in fiscal year 1975 to 60 projects and approximately 3,300 senior companions as of December 1978.

During 1978, five new SCP projects were initiated. Their purpose is to assist older people who are physically and/or mentally impaired and need support in order to maintain or resume independent living. A number of new concepts were incorporated into the program design to test the feasibility of replication among the existing projects. These include: (1) The integration of senior companions into a plan of care developed by community organizations with the capacity to coordinate the health and social needs of clients served; (2) enrichment of volunteer training; and (3) broadening the community's role in the structure and composition of advisory councils.

In November 1978, 59 projects attended a 5-day national senior companion conference in Washington, D.C. Training focused on development of health care plans, deinstitutionalization of older patients from mental institutions, acute care hospitals and nursing homes, advocacy, direct health care providers as volunteer stations, and transportation planning.

RETIRED SENIOR VOLUNTEER PROGRAM (RSVP)

The retired senior volunteer program was established to provide a variety of meaningful opportunities for persons of retirement age to participate more fully in the life of their community through significant volunteer service.

Originally authorized under the Older Americans Act Amendments of 1969, RSVP became operational in June, 1971 when the Department of Health, Education, and Welfare (Administration on Aging) funded 11 projects. In July, 1971, the program was transferred to ACTION in accordance with Executive Reorganization Plan No. 1. Current authorizing legislation is title II, part A of Public Law 93-113, the Domestic Volunteer Service Act of 1973, as amended.

ACTION grants are awarded to local public agencies and nonprofit private organizations to support the development and operation of RSVP projects providing volunteer opportunities for persons 60 years of age and over. RSVP volunteers receive no compensation for their services, but reimbursement is provided for transportation between their homes and volunteer assignments. Accident and liability insurance are also provided.

As an inherently local program, each RSVP project is locally planned, operated and controlled, and supported on a cost-sharing basis. The local match starts at 10 percent the first year, 20 percent the second and for the third and subsequent budget periods remains at a maximum of 30 percent for the local share and 70 percent for the Federal contribution. Exceptions to this requirement may be granted by ACTION in individual cases of demonstrated need.

RSVP projects encourage organization and agencies to develop a wide variety of volunteer service opportunities for retired persons, aged 60 years or over. The focal point of RSVP activity is the preference of the volunteers, for whom community service opportunities are arranged to match their interests, abilities and physical capabilities, as well as the needs of the community. There are no income, education, or experience requirements to becoming an RSVP volunteer. Orientation and in-service instruction are provided for volunteers. Older adults, including minorities, the handicapped and isolated elderly, are sought and encouraged to contribute their time and experience in service to their communities. Assignments arranged for RSVP volunteers offer varied opportunities to serve people of all ages, directly or indirectly.

ACTION grants are awarded to publicly owned and operated facilities or projects and to private, nonprofit organizations. Volunteers serve in innumerable assignments involving health and nutrition, education, economic development, housing, energy and conservation, community services, and legal rights.

Since 1971, the retired senior volunteer program has experienced dramatic growth. As of December 1978, there were 682 federally funded projects, plus 11 which were completely locally supported. Approximately 250,000 volunteers now serve in projects located in all 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. Many States now appropriate funds to support RSVP projects. On the basis of the 1978 Federal appropriation of $20.1 million for the retired senior volunteer program, annual Federal cost per volunteer is estimated at slightly over $80.

In December 1973, a study of the retired senior volunteer program identified benefits derived from participation in RSVP by both senior volunteers and volunteer stations. Nearly three-fourths of volunteer stations included in the study indicated that RSVP volunteers provided a valuable supplement to their staff, and nearly two-thirds stated that they would be forced to cut services or activities in the absence of the RSVP volunteers. More than half of the RSVP volunteers included in the study indicated that they felt better physically, and nearly four-fifths stated they felt better mentally, due to their volunteer experience. In addition, study data indicated that a majority of RSVP volunteers who lived alone experienced an increase in community involvement and a reduction in isolation as a result of RSVP.

A 1978 RSVP descriptive survey indicated that 78 percent of RSVP volunteers are women, the majority of whom are widows living alone. The majority of made volunteers, are married and living with their spouses. The average age for all volunteers is 70.3 years, with 11 percent 80 years of age or older. The ethnic backgrounds compare closely with that of the total U.S. population over 65 years of age. The median number of volunteers per project is 296, only one-fourth of whom are transported or request reimbursement for transportation. Sixty-two percent had no or only limited prior volunteer service. Ninety percent of RSVP projects have four or fewer full-time equivalent staff members. Forty-one percent of projects coordinated activities with other ACTION programs, mainly VISTA and the foster grandparent program.

Numerous examples illustrate the value of the contributions of RSVP volunteers to their communities.

An RSVP volunteer in Roanoke, Va., a retired pharmacist now serves in the "free clinic" in Roanoke. In addition to the time he spends stocking shelves and checking inventories, he serves as a pharmacist in the clinic two evenings a week.

The RSVP project in Richmond, Ind., in cooperation with the Family Service Association and big brothers/big sisters, offers computerized services in home energy conservation to residents of the community.

In Snohomish County, Wash., an RSVP volunteer, whose degrees range through Ph D. in biochemistry, assists in the middle school industrial arts class at the sixth grade level. Because he "likes to be kept busy," this volunteer receives a tremendous satisfaction from using his special talent for teaching young people. The class instructor states, "We just can't do without him."

In the Plymouth (Mass.) County probate court, RSVP volunteers serve as "court grandparents" in separation or divorce preceedings where there is concern about the welfare of the children involved. Because of the success of the program, the probate judge has recently requested an expansion in the number of RSVP volunteers who serve. In other projects throughout the country RSVP volunteers serve as tutors for juvenile offenders, give counseling and guidance to persons on probation, serve in courts, prisons, and half-way houses.

In the fall of 1978, RSVP designated 100 demonstration projects under the major categories of advocacy, deinstitutionalization/prevention of institutionalization, criminal justice, housing/food and energy conservation. An assessment of the accomplishments of these special thrusts will be made during the current year.

OLDER PERSONS IN VISTA

ACTION legislation requires that VISTA encourage, "fullest participation of older persons and older person membership groups as volunteers and participant agencies . . ."

A 1978 survey revealed that 20 percent of VISTA projects are involved in programs designed to serve older people living in poverty.

As of January 1, 1979, 14 percent of all VISTA volunteers were 55 years of age or older, including 164 persons who are 70 and older among the 612 volunteers in the over 55 category.

The following are examples of VISTA's serving older Americans:

Senior Federation Services of Minnesota, St. Paul, Minn. (10 volunteers)

The Senior Federation Services of Minnesota has been in existence since 1973 when a group of clergymen and citizens concerned about the problems of seniors got enough money to operate a full-time program. From a small organization it has grown into a statewide program with over 180,000 members. VISTA's have been instrumental in this growth from their arrival in 1974. Presently, there are ten VISTA's on the site. One of them is developing a model for discount buying which will be implemented throughout the State. Within 1 year she has succeeded in getting over 100 stores in her region (the Federation divides the State into 12 regions) to offer discounts on food, medical treatment and drugs, and clothing to seniors. Her success has attracted the attention of local colleges who have invited her to speak and give workshops as well as that of the State Governor.

The federation, as a whole, has set up medical programs for seniors; successfully lobbied for weatherization laws; been instrumental in the State passing 11 laws concerning the upkeep of nursing homes; and successfully fought against power and light increases during the past 2 years. All of the VISTA's are involved in one or more of these areas.

Through the federation's efforts, which have resulted in the many savings listed above, the seniors of Minnesota can now look forward to an economically more secure future.

New York State Office for the Aging, Albany, N.Y. (16 volunteers)

A volunteer works in conjunction with a RSVP program in a small town in upstate New York. She works primarily with handicapped elderly people who still have much to offer to the community but who are isolated due to their handicap. The volunteer works with various agencies and businesses to establish volunteer positions and then matches the elderly clients with a suitable position.

In addition, through her work, it was discovered that there were a great many architectural barriers within the town which inhibited the mobility of the handicapped population. The volunteers organized a committee of interested elderly people to study the problem and publish a list of agencies, businesses, restaurants, and other services that were accessible to handicapped persons. This group will continue operating to establish building codes within the town. The group has advanced to the point where they will survey a business for architectural barriers even though it may cause hard feelings.

The volunteer has also been able to acquire some title IX positions which will allow qualified elderly people to work in the community and to possibly continue the work the VISTA volunteer has started.

National Citizens Coalition for Nursing Home Reform: Larimer County Council on Aging, Fort Collins, Colo.

In Colorado, a 68-year-old retired professor, who was trained in nursing home advocacy by the State of Colorado's ombudsman program, has reenrolled as a VISTA under the national grant to National Citizen's Coalition on Nursing Home Reform. In her first year as a VISTA, the volunteer helped create the Nursing Home Task Force of the Larimer County Council on Aging in Fort Collins, Colo., and in turn recruited about 100 people willing to regularly visit nursing homes in Fort Collins and Loveland. Under the grant, the VISTA will coordinate their visits and the work of a committee which deals with the problems in homes uncovered by the visitors to help them be more sensitive and effective in recognizing real problems as they arise; and also will work with resident councils in five nursing homes in Fort Collins.

The volunteer has been a tireless worker to improve the quality of life in the area's nursing homes. She has sought to shorten the intellectual and emotional distance between the nursing home and the community.

ITEM 13. CIVIL AERONAUTICS BOARD

JANUARY 8, 1979.

DEAR SENATOR CHURCH: You asked for a summary of our major actions and programs and those within the airline industry related to aging in 1978, and of those planned for 1979. Your letter of December 1 states that this summary is to be included in the annual report of the Senate Special Committee on Aging.

By P.L. 95-163, the Congress amended the Federal Aviation Act, permitting the airlines to offer reduced-rate transportation on a space-available basis to any retired person 60 years of age or older, or to any person 65 years of age or older. The amendments defined "retired" as "no longer gainfully employed," as defined by the Board. In February 1978, the Board issued a notice of proposed rulemaking to ask for public comment in defining this term. In response to the numerous comments received, "no longer gainfully employed" or "retired" has been defined in Part 223 of our Economic Regulations (14 CFR Part 223) to mean those not regulorly working at a full-time paying job, and not intending to do so in the future. This definition reflects the Board's interpretation that Congress intended to include only those who have permanently reduced their working time, or who have permanently stopped working altogether.

Most airlines now offer space-available discount fares at 33⅓ percent to any person 65 years or older. As a result of consumer pressure, however, many airlines now allow 24-hour periods before flight time during which any elderly person has the opportunity to reserve a seat. These reservations are generally on a first-come basis, although several airlines retain the right not to accept these reservations on flights that are likely to operate at or near full capacity. Again, because of consumer pressure, most of the airlines now intend to eliminate their present requirement for these reservations that a person purchase an identification card to be eligible for these discounts. Proof of age, however, will be a continuing requirement. These fares and the rules for them are, of course, within the control of the airlines.

Also in February 1978, the Board appointed a representative to the Interagency Task Force on Aging to assist the Department of Health, Education, and Welfare in developing regulations to prevent age discrimination. The Board staff reviewed for potential age discrimination all our existing regulations and the federally funded assistance programs under our jurisdiction. We are continuing this procedure for each of our proposed rules, and for implementation of the Airline Deregulation Act and its assistance program for small community air service.

We would also stress that our recent policy, combined with major changes of the Airline Deregulation Act, reducing Board authority over airline fares, has created the atmosphere for many innovative low-price service offerings available to all travelers, and that atmosphere should improve as the Airline Deregulation Act takes effect. For example, the Board has set up a pricing zone for passenger fares, in which airlines may cut substantially or raise slightly their fares without Board interference. The Board has also simplified and liberalized its charter rules, providing greater opportunities for this type of low-cost travel. These changes should result in a vigorously competitive airline industry beneficial to all travelers, and particularly to those elderly who may have previously found the cost of air transportation prohibitive.

Other than monitoring these rules and implementing the Deregulation Act, we are not considering any other actions that might relate to aging during 1979.

I trust this provides the information you need.

Sincerely,

MARVIN S. COHEN, *Chairman.*

ITEM 14. COMMISSION ON CIVIL RIGHTS

MARCH 16, 1979.

DEAR CHAIRMAN CHILES: We are pleased to respond to your invitation to submit a summary of the Commission's major aging-related activities in 1978. Enclosed is our report on these activities. We hope it offers a useful addition to the committee's publication for this year.

If you have any questions, please have Mr. Lipscomb or another member of your staff contact Lucy Edwards at 254–6626.

Sincerely,

LOUIS NUNEZ,
Acting Staff Director.

Enclosure.

MAJOR ACTIONS BY THE COMMISSION ON CIVIL RIGHTS ON AGING DURING 1978

The Age Discrimination Act of 1975 (part of the Older Americans Amendments of 1975 [Public Law 94–135]) directed the U.S. Commission on Civil Rights to carry out a study of unreasonable discrimination based on age in programs and activities receiving Federal funds. Following this mandate, the Commission examined in-depth selected aspects of the field of higher education and the following 10 federally assisted programs:

Community mental health centers, authorized by the Community Mental Health Centers Act, as amended.

Basic vocational rehabilitation services program, authorized by title I of the Rehabilitation Act of 1973, as amended.

Training and public service employment programs, authorized by titles I, II, and VI of the Comprehensive Employment and Training Act (CETA), as amended.

Legal services program, authorized by the Legal Services Corporation Act of 1974, as amended.

Adult basic education program, authorized by the Adult Education Act of 1966, as amended.

Food stamp program, authorized by the Food Stamp Act of 1964, as amended.

Medical assistance program (medicaid), authorized by title XIX of the Social Security Act, as amended.

Social services to individuals and families, authorided by title XX of the Social Security Act, as amended.

Community health centers, authorized by title III of the Public Health Service Act, as amended, and

State vocational education basic grant program, authorized by the Vocational Education Act, as amended.

The Commission also conducted four public hearings. The study was carried out over an 18-month period beginning in July 1976.

On January 10, 1978, the Commission released the report of its age discrimination study, setting forth its findings and recommendations. After weighing the evidence gathered from the study's field investigations and the public hearings, the Commission concluded:

> That barriers have been erected by both public and private administrators between persons falling within particular age groups and services which are financed in whole or in part by the Federal Government.
>
> That erection of these barriers is having a serious adverse impact on the lives of children and older persons who need these services.
>
> That practices are being followed which are in direct conflict with the concept of the dignity and worth of the individual.

On examining the reasons that were and continue to be advanced for using age as a barrier to the delivery of services supported by the Federal Government, we concluded:

> That none of these reasons constitutes a valid basis for disregarding the needs of individuals falling within these age groups.
>
> That all such barriers constitute "unreasonable discrimination" on the basis of age and should be prohibited by law.
>
> That exceptions to this principle should be made only by the Congress; no authority should be granted to public or private administrators who administer programs supported by Federal funds to make such exceptions.

The Commission concluded further that some statutory modifications were necessary to improve the effectiveness of the Age Discrimination Act. Several of these recommendations were adopted by the Congress when it amended the act in 1978 (Public Law 95–478). In particular, the term "unreasonable" was stricken from the purpose clause of the act, and a private right of action was made a part of the enforcement provisions.

In addition to the study report, the Commission also published the transcripts and exhibits from the four public hearings held in San Francisco, Calif.; Denver, Colo.; Miami, Fla.; and Washington, D.C. The Commission has just recently published (January, 1979) volume II of the age discrimination study report, which was completed in 1978. Volume II describes the methodology that was employed to execute the study, and summarizes on a program-by-program basis the record of information obtained through literature search, data analysis, the field studies, and the public hearings.

As part of the study followup effort, the Commission has worked with the Department of Health, Education, and Welfare and others in connection with proposed regulations to implement the Age Discrimination Act, as amended.

Except for the special short-term mandate of the Age Discrimination Act, the Commission's statutory jurisdiction did not extend to age discrimination. However, the Civil Rights Commission Act of 1978 (Public Law 95–444), which extended the life of the Commission, also granted jurisdiction over the area of age discrimination to the Commission. This legislation was enacted into law on October 10, 1978. During the remainder of the calendar year, the Commission was engaged in developing plans to implement the new jurisdiction; however, further program action is contingent on receiving the necessary appropriations.

Other congressional action will also affect the Commission's aging-related activities. As part of the 1978 Older Americans Act Amendments (Public Law 95-478), Congress has directed the Commission to conduct a study of discrimination based on race or ethnicity in federally supported programs for older persons. Appropriations are not yet available to implement the study.

ITEM 15. COMMUNITY SERVICES ADMINISTRATION

FEBRUARY 12, 1979.

DEAR MR. CHAIRMAN: We are pleased to submit the enclosed response to your request on the activities, funding, and services of the Community Services Administration (CSA) for the elderly poor people of our country. We are indeed sorry there has been such a delay in getting this information to you. Please accept our apologies.

From the inception of CSA's Senior Opportunities and Services (SOS) program, it has played a major role in reshaping the focus of many social services and the methods of their delivery by many agencies.

The Community Action Agencies (CAA's) and the SOS program pioneered outreach and referral, housing assistance, legal services, employment, and a variety of other services for elderly poor people. The primary role of the SOS program has been that of innovator and coordinator of local, State, and Federal programs for low-income elderly citizens. The program has also served as a measuring tool to assess the effectiveness of many larger and stereotyped programs operated by other Federal agencies.

We feel that the CAA's and SOS program designs and operations have reflected new and imaginative to reach and work with elderly poor people. Our experiences indicate that our special efforts in their behalf have resulted in their being better informed about the services to which they are entitled, even though in many cases the special programs may not have been in existence at that time in their community. As a result of these special overtures, a new sense of trust has developed between elderly poor people and community action people.

This new trust has undoubtedly been a major contributing factor in the success of the SOS program.

If you have further questions, please let us hear from you.

Sincerely,

GRACIELA (GRACE) OLIVAREZ,
Director.

Enclosure.

1978 ANNUAL REPORT OF THE COMMUNITY SERVICES ADMINISTRATION'S PROGRAMS AND ACTIVITIES FOR THE ELDERLY POOR

Since 1937, many Federal agencies have been established to provide assistance to the Nation's elderly. While these agencies have responsibilities in providing services to or assisting the elderly, only CSA has been specifically mandated by Congress to meet the needs of older Americans in poverty. In many ways the older poor are the most vulnerable of the poor and least able to help themselves.

CSA's programs for the older poor are funded from the agency headquarters through the regional offices to local grantees. Most grantees are CAAs or their delegate agencies with a few limited exceptions. These programs are authorized and funded to provide financial assistance to agencies for the planning, conduct, administration and evaluation of community action programs and components, including activities and facilities designed to assist the older poor to:

(1) Secure and retain meaningful employment.

(2) Make better use of available income.

(3) Provide and maintain adequate housing and a suitable living environment.

(4) Obtain emergency assistance through loans or grants to meet immediate and urgent family needs, including the need for health services, nutritious food, housing, and employment related assistance.

(5) Remove obstacles and solve personal and family problems which block the achievement of self-sufficiency.

(6) Achieve greater participation in the affairs of the community.

(7) Make more and effective use of other programs designed to assist them.

CSA'S POLICY ON THE OLDER POOR

CSA's policy on the older poor will focus on the goals of promoting the highest possible level of independent living, prevention or delay of institutionalization, providing supportive services especially for the functionally dependent, increasing the access of the elderly poor to services, and aiding in the elimination of discrimination on the basis of age.

DEMOGRAPHIC INFORMATION

The number and percentage of the population which is elderly has grown significantly in the past 70 years. Today, 15 percent of the population is over age 60 and by 2035, 24 percent will be over age 60. This growing older population has raised and will continue to raise a number of important policy and program issues. The basic issues will be income, employment, energy, housing, health, nutrition, safety and transportation.

Older Americans in poverty are a special older adult population with extensive needs. In 1975, the number of older persons in poverty totaled 4.3 million with an additional 3 million "near poor," i.e., with incomes less than 125 percent of poverty.

Minority elderly, female elderly and persons age 85 and older are growing, poor populations with extensive needs. These populations share the general problems of all older adults but experience unique problems of access to services and have fewer resources to resolve their problems.

FEDERAL AGENCIES SERVING THE ELDERLY AND THE POOR

Many agencies are designated to provide services to older adults. However, CSA has been specifically mandated by Congress to meet the needs of the poor. The elderly poor are, in many ways, the most vulnerable of the poor. The maintenance of a focus on the needs of the elderly poor, their inclusion in decision-making roles and the representation of their interests remain important functions. These functions can best be carried out by an independent agency which has experience in assisting the poor, which can work cooperatively with other agencies, yet carry out constructive advocacy for the benefit of older persons in poverty.

CSA'S FUTURE ROLES IN SERVING THE OLDER POOR

1. Outreach and Follow-Through

CSA, through its Community Action Agency (CAA) network and Senior Opportunities Services, has assisted and continues to assist older adults to obtain services which they need and for which they are eligible. CSA programs have been able to press the issue of access to services beneficial to low income older adults.

CSA should continue and, if possible, expand these activities and devise new outreach and follow-through mechanisms, especially to assist minorities, non-English speaking, the homebound and the institutionalized. Without adequate outreach and follow-through, the elderly poor, in effect, are denied services for which they are eligible.

2. Advocacy

Vigorous advocacy at national, State, and local levels is required for older Americans in poverty who, for the most part, lack an organized constituency voice. Previously, CSA programs have brought about program and policy changes and mobilized reasources for groups of older poor. As new policies and programs are developed, CSA and its State and local grantees continue to advocate directly and to assist national and local public interest advocacy efforts that bring about the recognition of the needs of elderly poor and the allocation of resources to meet those needs.

3. Research and Demonstration

CSA has, both through its SOS and other research and demonstration efforts, developed and demonstrated new approaches in, for example, employment, crime prevention, and housing. These demonstration efforts will be expanded, especially in areas of basic needs such as income, housing alternatives, health care, legal and consumer education services, nutrition and transportation.

4. *Coordination*

The coordination of all resources to serve and maximize benefits for the older poor is a principal concern of CSA. Developing, strengthening and consistently implementing working agreements with those agencies who have resources which could be made more available to the elderly poor are of central importance. CSA will continue to pursue operational working interagency agreements at the federal, state and local levels.

5. *Organizational Capacity*

In order to implement the above recommendations, adequate resources to provide training and technical assistance, to monitor progress and evaluate results are required. Appropriate staffing to carry out these functions is being developed at all levels in the CSA and CAA structure.

MANDATES AND SERVICES OF CSA AND OTHER FEDERAL AGENCIES SERVING THE ELDERLY

1. *Broad CSA Mandates for the Poor and Elderly Poor*

The purpose of CSA, as set forth in the Economic Opportunities Act (EOA) as revised in 1974, is to "eliminate poverty in this Nation by providing to everyone the opportunity for education and training, the opportunity to work, and the opportunity to live in decency and dignity".

CSA works to accomplish those goals by making local, state, private and federal resources available to low-income families in both urban and rural areas so that they can obtain skills, knowledge, hope and the full dignity of a self-sufficient life style.

CSA is directed to realize its purposes through the following methods:

(*a*) To strengthen community capabilities for planning and coordinating activities.

(*b*) To improve the organization of the range of services related to the poor.

(*c*) To develop and use new and innovative approaches in eliminating individual and structural poverty.

(*d*) To develop and implement programs serving the poor with maximum feasible participation of the residents of the area.

(*e*) To broaden the resource base of programs through securing the assistance of the public and private sectors; including business, labor, religious and charitable organizations and neighborhood and professional groups.

2. *Statutory Mandates Related Specifically to Elderly Poor*

The Senior Opportunities and Services Program (SOS) was created by EOA in response to the special needs of older, poor persons above the age of 60. SOS accomplishments have been in the following areas:

(*a*) The creation of new employment and volunteer opportunities.

(*b*) Effective referral to existing services including: health, income, employment, housing, legal, consumer, transportation, education and recreational services.

(*c*) Stimulation and creation of new programs and services to remedy gaps and deficiencies in existing programs.

(*d*) Modification of existing procedures and eligibility requirements in existing programs such that these programs become more accessible to the older poor.

(*e*) Development of recreation and multipurpose centers.

In addition to SOS program activities, Congress has mandated that CSA consult with other agencies and organizations to develop and implement a plan for the participation of the elderly poor in programs.

CSA is required to review all programs to assure that the elderly poor have consistent and continuing access to community resources. It also must maintain interagency liaison with other Federal agencies to achieve a coordinated rational approach to meeting the needs of the elderly poor.

Finally, CSA is required to recommend to the President and Congress the programs that require additional funding and the necessary legislation to provide authority for such funding.

3. CSA and Other Federal Agencies; the Special Nature of the CSA Experience and Mandate

By mandate CSA is the only agency whose sole focus is on services to the poor and near poor. While part of the mandate of a number of other agencies, for CSA, services to the low-income community is its only task.

The enabling legislation of CSA mandates the maximum feasible participation of the poor including the elderly poor in the planning and implementation of all programs. This is not a requirement of other Federal agencies. Other agencies are certainly sensitive to consumer input and may be required to have the poor represented on policy bodies, but do not have a directive to assure maximum feasible participation of the poor.

Through its network of CAA's, CSA has in place a capacity to conduct aggressive advocacy, outreach and follow-through to assist the elderly poor, in many cases, the most forgotten and neglected of minorities.

Other agencies do not have the institutional capacity to conduct such aggressive advocacy and outreach. Further, it is understandably difficult for many national agencies to maintain a sharp focus on the special needs of the elderly poor when their mandate includes the needs of all elderly.

SENIOR OPPORTUNITIES AND SERVICES

The senior opportunities and services (SOS) program authorized as a special emphasis program for the elderly poor by the Economic Opportunity Act of 1964 (as amended) has demonstrated exceptional versatility as a program vehicle with activities ranging from service delivery to advocacy. It serves as the Community Service Administration's primary program for identifying and meeting the special needs of the elderly poor. Grassroots projects, most of them operated through community action agencies, are utilized by the program to help the elderly poor help themselves.

In furthering this goal, the projects must serve and employ persons age 60 and over; provide the elderly poor with the opportunity to plan and design their programs; and deal with those specific problems of the low-income elderly not being addressed by programs serving multigenerational groups. Additionally, the SOS projects serve as a medium for the elderly and local programs designated to serve older Americans.

In 1978, CSA funded 199 SOS projects at a cost of $10.5 million. In addition to the projects funded with SOS monies, 582 CAA's operated "identifiable" older persons program with CSA funds. These projects provided a variety of services ranging from recreation to employment for over 2 million aged poor. The projects in their design provided the maximum opportunity for the elderly poor to develop, direct and administer such programs, while utilizing existing services and other programs to the maximum extent feasible. Also, CAA's throughout the 10 regions operated more than 526 older persons programs with funds from other Federal agencies.

CSA grantee impact on the well-being of the elderly has been substantial despite static SOS funding levels. CSA's appropriation when measured in terms of resources mobilized for and on behalf of the elderly poor highlights the effectiveness of these funds as a leverage tool assuring the delivery of unduplicated services to more than two and a half million elderly poor at the local level.

Perhaps most importantly, SOS has provided an effective network of services to enable elderly persons to live independently in their own homes.

One of the most innovative and successful of CSA's program operations is the funding of statewide organizations of senior groups. This new concept of organizing on a statewide level older poor persons and other groups of seniors is currently functioning in eight states: New York, North Carolina, Colorado, Montana, North and South Dakota, Utah, and Wyoming.

These statewide organizations, in addition to the Mountain Plains States Congress of Senior Organizations which coordinates the efforts of all six States in region VIII, continue to make rapid growth in their advocacy efforts resulting in new legislation and institutional change benefiting not only older poor persons but all the poor residing in their respective states.

ILLUSTRATION OF SOS PROJECTS

The San Diego County Community Action Partnership administers two SOS programs, one in Imperial Beach and one in the city of San Diego. The latter is funded from earmarked SOS funds ($65,000) and the former from local initiative funds ($43,200).

The primary goals of both these programs are to:

(*a*) Prevent poor elderly citizens, especially shut-ins from becoming isolated from the larger community.

(*b*) Give necessary assistance to keep the elderly in their homes and avoid premature or unnecessary institutionalization.

(*c*) Provide advocacy on behalf of the elderly poor and make their plight known to the larger community.

(*d*) Provide referral and emergency social services when needed.

The strategies employed to meet these goals are the provision of group activities such as communal meals, craft classes and other appropriate social activities; provision of transportation, and escort services, provision of assuring phone calls on a regular basis to shut-ins and visitations; provision of legal services, tax assistance, consumer protection information, and emergency food and clothing; and publication of a monthly newsletter.

Due to its favorable climate, and close proximity to Mexico, San Diego County attracts a large number of retired people from all parts of the country, being one of two favorite spots for military retirees. (Florida being the other.) As the funding indicates, the earmarked SOS funds are supplemented from local initiative monies to provide but the barest minimum of services to the elderly poor of San Diego County.

RURAL SOS PROGRAM

The Puerto Rico Community Services Administration (PRCSA) (grantee #21477) operates several rural SOS projects. One such project is located in the municipality of Ceiba. The municipality of Ceiba has a population of 55,000 persons of whom approximately 15 percent are elderly and poor.

The SOS project which serves this area is housed in a municipal structure donated by the city government. The project, known to local residents as Centro Ancianos, serves approximately 500 residents on a regular basis providing an array of services such as health services, nutrition, recreation, social and psychological services, transportation, employment counseling, arts and crafts instruction and general education.

Under the general direction of the grantee, operational policy is set by a local council composed of 15 members most of whom are elderly. In cooperation with local government agencies, the project's staff carries out policy as set by the council. The staff which includes an administrator, outreach workers, cooks, teachers and a custodian, recruits elderly volunteers from the community to provide needed services which the project is unable to finance.

On a typical day at this project, a visitor would find approximately 100 elders (predominantly men) engaged in various activities. For example, there would be a nurse/doctor team providing medical services to several clients; there would be a teacher conducting an arts and crafts class for another group (many items are sold and the elders benefit); another group might be discussing a community or project problem in search of a solution; another group might be engaged in a game of dominoes (spectators at hand); still another group will be simply watching television or as they do at Christmas and local holidays singing and dancing under the guidance of a volunteer; and finally, another group will be assisting the custodian or the cooks as they prepare the day's luncheon.

All of these activities are financed by an annual grant of $75,000 from CSA and local cash and in-kind contributions in excess of $100,000. Centro Ancianos is an active project, well known and fully supported by Ceiba community.

OTHER SPECIAL EMPHASIS PROGRAMS

I. Community Food and Nutrition Program

Farm to parking lot markets have provided lower cost food to the urban elderly poor. By eliminating middleman costs CFNP funded projects have made nutritious and fresh foods available to city dwellers. Farmers bring their products from their trucks to established farmers' markets.

The absence of meals-on-wheels legislation has not stopped the CFNP funded projects—which provide needed assistance to the home-bound elderly. CFNP projects have tightened their belts, and scrounged for local funds so these vital projects will continue until Federal meals-on-wheels legislation and appropriations are enacted.

Older persons are participants and also the beneficiaries of community garden projects in West Virginia, Oklahoma, Alabama, Wisconsin, Maine, and other States and communities. CFNP funds buy seeds, fertilizer, and tools where necessary. Younger people from CETA and various youth programs do the physically demanding gardening tasks thereby making it possible for the elderly to do what they can and also harvest the produce.

Communty canneries started with CFNP funds provide nutritious, low-cost food for the elderly poor. By using locally grown foods at harvest times, when prices are lowest, the canneries provide food which may be consumed throughout the year.

A new project called "stamp out hunger" has been proposed to the administration on Aging by a CFNP grantee. The idea behind the project is to use title III nutrition sites for distributing food stamp information and for certifying eligible people. The CSA grantee is also negotiating with AoA so the new AoA regulations will have input based on the CSA's grantees long experience in nutrition programs. CSA's national network of community antihunger organizations extend to rural and urban communities throughout the Nation.

The Senior Citizens Market in Wilkes-Barre, Pa., had its grand opening on December 20, 1978. Located in the Mercantile Center the store will provide a complete line of grocery items, at a savings of 15 percent to an estimated 1,500 elderly per month.

The $50,000 startup monies were pooled from community food and nutrition program funds, $10,000 from the local area agency on aging and $30,000 from the Council of Churches and other religious groups in the area. Funds for continuing the market will come from other sources.

II. Rural Housing Demonstration Program

The community action agencies and other limited purpose agencies funded by CSA have indicated in a recent survey that they place housing among the top of priority needs of the poor whom they are serving. With $21 million in local initiative funds and about $6 million in R&D funds, CSA is supporting programs for more than 500 such agencies that provide housing and housing services for the poor in their communities.

Elderly persons, who as a group are the most desperately in need of housing assistance, generally are the greatest beneficiaries of the housing program. This is particularly true with the extensive work that is being done with rural home repair projects. The agency funding enables local organizations to help poor residents of the community qualify for Farmers Home Administration loans and grants. It also then undertakes, often with CETA labor, the actual repair of the home. The elderly poor (over 62) especially benefit from this program as they may become eligible for an out-right grant if their incomes are too low to qualify for the low interest (1 percent) FmHA home repair loan.

An example of one of a number of R&D housing projects for the elderly is the construction of a multifamily unit in Siler City, N.C. In this instance, the CSA funded Low-income Housing Development Corporation of North Carolina is providing technical expertise of housing to the local community action agency which is helping a nonprofit organization (a small black church) to obtain a FmHA mortgage loan for the construction of the building and HUD section 8 rent subsidies to house forty elderly families.

III. Energy Programs

During 1978 CSA grantees weatherized approximately 300,000 homes of the poor and near poor, bringing the total number of houses weatherized since inception of the program to over 600,000. A large percentage of these houses were occupied by the elderly. Even though DOE monies first became available in substantial amounts, the total number of dwellings weatherized was substantially below expections due to the great difficulty many local agencies experienced in obtaining CETA workers to carry out the weatherization.

In addition to weatherization, CSA grantees also carried out energy conservation education programs and provided several hundred low cost solar water and space heaters to low income households, many of which included the elderly.

In 1978, CSA and its grantees again carried out emergency assistance which, like the previous year's special crisis intervention program (SCIP) provided assistance in paying of fuel and utility bills. The 1978 program, emergency energy assistance program (EEAP), provided assistance to 466,000 elderly persons.

In addition to these operational programs, CSA has funded the Portland, Maine, Catholic diocese to carry out a personal energy program (PEP) which provides a package of warm clothing and an electric blanket to elderly persons facing the danger of hypothermia. A component of the program is also, through the University of Maine, studying the problem of hypothermia which will assess the extent of the problem and steps which can be taken to avoid it. PEP has provided assistance to several hundred elderly persons, as well as working with local craft cooperatives in the production of hats, boots, gloves, and quilted vests.

CSA'S INTERAGENCY AGREEMENTS

CSA is cooperating with more than 10 Federal agencies to define areas of information and referral, that will be most beneficial to the program participants. We are seeking to avoid overlap of services wherever a public or a private nonprofit agency is already doing a good job. A new report on the agencies' varieties of I&R has just been printed and new editions are planned to be printed and distributed as the respective agencies broaden their areas of I&R coverage and provide in simple, everyday language, both in English and Hispanic, the most current information on the older Americans' entitlements.

CSA is also exploring with the Administration on Aging (AoA), OHR/DHEW more innovative and fruitful interagency agreements to serve as the basis to ensure that all possible older Americans benefit from the AoA and CSA programs. We see these programs as being complementary rather than duplicatory and CSA's programs filling in the gaps of services where they exist or providing services wheer they are nonexistent.

The departments of USDA, HUD and DOL are also to be focal points where we hope to enter into inter-agency agreements and join in new and experimental programmatic endeavors.

CSA'S RESEARCH AND PILOT PROGRAMS

The CSA research and pilot programs support new projects which test the feasibility of different approaches to old problems of the older Americans. They also supplement existing knowledge in a variety of problem areas which are growing more acute and numerous for the older low-income American.

In response to some of these problems four Federal agencies and the Ford Foundation are engaged in the second year of the national elderly victimization prevention and assistance program. The national program consists of seven local demonstration projects in six cities, a central coordinating agency and a long-term impact evaluation of the effectiveness of the projects.

This joint undertaking by CSA, LEAA, and HUD began in 1977 to demonstrate how to reduce and prevent crime against the elderly. The projects were established in six large cities, including two in New York City. CSA is funding three of these projects—New York City, Milwaukee, and New Orleans—at an annualized amount of nearly $750,000.

Some of the results from the CSA projects of the national demnostration program in fiscal year 1978 are:

1. *Helping the elderly avoid victimization.*—All of the projects offer crime prevention education to senior citizens. Information is given so that the elderly can modify their daily routines, making them less vulnerable to robberies, burglaries, purse-snatchings, and other crimes. New York's "senior citizens' crime assistance and prevention program" (SCCAPP) developed packets for senior citizens which contain pamphlets and fact sheets on crime prevention strategies. The New Orleans program, elderly victimization prevention and assistance program (EVP&AP), uses both a local volunteer group, Women Against Crime, and the police to help conduct presentations. The Milwaukee project uses skits and role-playing to dramatize important crime prevention techniques.

2. *Home security* also helps senior citizens increase home security by surveying weaknesses and needed improvements. The Milwaukee crime prevention-victim assistance program pays for new equipment such as door viewers or locks. All of the demonstration projects conduct "Operation Identification," engraving valuables with identifying numbers to discourage burglaries and deter fencing or speed up recovery of stolen articles. In New Orleans, Operation I.D. is part of the home security surveys.

3. *Reestablishing social networks.*—All projects organize and supervise neighborhood strengthening programs. The Milwaukee project uses organizers who go

door-to-door in two target areas urging citizens to join together in block clubs. In the Sherman Park area alone approximately a dozen clubs have been established. However, all projects have found it difficult to organize transitional neighborhoods where people move frequently. These communities, where the crime rate is highest, require new kinds of techniques, some of which are being developed and tested.

4. *Aiding the elderly victims of crime.*—All projects provide victim assistance and the kind of personal attention which they do not always receive at other social service agencies. The New Orleans project picks up victimization data from the police on all crimes committed throughout the city, then reviews them to identify elderly victims. New York City's SCCAPP sends staff to the local precincts to review police crime reports. Staff members contact victims as soon as possible after the crime ot make an assessment of what is needed. Case workers provide the aid directly or through referral. The New Orleans project is able to channel victims to a restitution program run by the parish sheriff's office.

Although five of the seven projects are in states with a victim compensation program, efforts to get financial compensation for elderly clients have generally proved futile, indicating the need for a number of changes to better meet the needs of elderly victims.

5. *Expanding public awareness.*—Projects advocate for public policy changes which will reflect the seriousness of crime against the elderly. While the non-CSA funded program in New York City has moved to disseminate information within the city, the CSA-funded program has extended its public policy activities to the State level. It has organized an elderly ad hoc crime planning group and has adopted a series of resolutions recommending legislation affecting the elderly and crime which have been forwarded to the Committee on Aging of the New York State Assembly.

EVP&AP staff have organized the New Orleans Federation on Aging, a coalition of approximately 20 representatives from local groups. The coalition has been incorporated within the past 3 months.

Another research and demonstration project approach and funded by CSA at the close of the fiscal year is a cooperatively-funded "university centers demonstration project for seniors" sponsored by the National Council on Aging's intergenerational services program. Funds are also supplied by NCOA and the Robert Wood Johnson Foundation. This project will enable NCOA to test a campus-based community service /learning center in seven college centers, with 13 universities, colleges and seminaries involved, across the Nation. Such centers will use students to help the elderly in a variety of ways—social services, classes, health care, and home-help.

The project, while providing much needed assistance to the elderly poor, also provides jobs for college students and an introduction to many faculty members and academic disciplines to the field of gerontology. This communication between the old, young and university staff should provide valuable personal insights to both generations.

CSA in fiscal year 1978 received final reports on previously funded successful research and demonstration projects including Project EXITO (Spanish for success) in Natalia, Tex., to assist elderly rural Hispanic-Americans obtain the support necessary to remain in their homes, and project "employment options for the elderly poor," undertaken by the Institute for Regional Affairs of Bucknell University to test the feasibility of business and local government to provide jobs for the elderly in an economically-depressed area in central Pennsylvania.

ADVOCACY

In fiscal year 1979, CSA also awarded a grant to the National Senior Citizens Law Center for a legislative aid and advocacy training project. The elderly, perhaps more than any other group, rely upon governmental programs for their basic health, income and nutrition. The new project will build on the existing legislative, judicial, and administrative advocacy networks—of which NSCLC is already an integral part—by expanding them to include local, State, and regional CSA advocates for the elderly. An indepth training program will provide knowledge about the methods of effective advocacy. At least five regional or biregional training conferences will be held across the country in fiscal year 1979 and the NSCLC will provide legislative aid to CSA grantees to assist them in preparing public and written testimony on congressional bills introduced at the Federal and State levels and also city and county levels. The NSCLC will also provide legislative aid to CSA grantees in commenting upon proposed regulations or changes in existing public laws. The CSA will be engaged in advocacy training and legislative aid and not public politicking which CSA grantees are precluded from being involved.

ITEM 16. COMPTROLLER GENERAL OF THE UNITED STATES

JANUARY 16, 1979.

DEAR MR. CHAIRMAN: In response to your December 1, 1978, request for information on our major activities concerning aging, we are enclosing a list of reports issued during calendar year 1978 on reviews of Federal programs concerning the elderly (enclosure I). We have also included a list of jobs in process which concern the elderly (enclosure II) and a statement of the General Accounting Office's "in-house" activities for the elderly (enclosure III).

Copies of the issued reports are being provided to your office separately. A summary of the major findings and conclusions for each report is included in a digest bound in the report or in the letter transmitting it.

Sincerely yours,

ELMER B. STAATS,
Comptroller General of the United States.

Enclosures.

ENCLOSURE 1.—GENERAL ACCOUNTING OFFICE ISSUED REPORTS WHICH CONCERN THE ELDERLY

Title	*Date*
Report to the Chairman, Subcommittee on Health, Senate Committee on Finance, on Medicaid Insurance Contracts—Problems in Procuring, Administering, and Monitoring (HRD-77-106).	Jan. 23, 1978.
Letter to the Chairman, Subcommittee on Intergovernmental Relations and Human Resources, House Committee on Government Operations, on Listing of Physicians and Group Practices Receiving Over $100,000 in Medicare Payments (HRD-78-32).	Feb. 7, 1978.
Report to Representative Elizabeth Holtzman on the Social Security Administration Needs to Improve Its Disability Claims Process (HRD-78-40).	Feb. 16, 1978.
Report to the Congress on Number of Newly Arrived Aliens Who Receive Supplemental Security Income Needs to be Reduced (HRD-78-50).	Feb. 22, 1978.
Letter to the Secretary, Health, Education, and Welfare, on Actions Needed to Improve the Nutrition Program for the Elderly (HRD-78-58).	Feb. 23, 1978.
Report to the Chairmen, Senate Special Committee on Aging; Senate Committee on Human Resources; Subcommittee on Aging, Senate Committee on Human Resources; Subcommittee on Select Education, House Committee on Education and Labor; and House Select Committee on Aging; on the 1975 Amendments to the Older Americans Act—Little Effect on Spending for Priority Services (HDR-78-64).	Mar. 6, 1978.
Letter to the Chairman, Permanent Subcommittee on Investigations, Senate Committee on Governmental Affairs, on Review of Grant Funds to the Sacramento Foundation (HRD-78-62).	Mar. 6, 1978.
Letter to the Chairman, Permanent Subcommittee on Investigations, Senate Committee on Governmental Affairs, on Washington State's Procurement of Services from Electronic Data Systems Federal Corporation Under the Medicaid Management Information Systems Program (HRD-78-66).	Mar. 9, 1978.
Report to the Congress on Further Improvements Needed in Investigations of Medicaid Fraud and Abuse in Illinois (HRD-78-46).	Mar. 10, 1978.
Report to the Congress on Twenty-Year Military Retirement System Needs Reform (FPCD-77-81).	Mar. 13, 1978.

ENCLOSURE 1.—GENERAL ACCOUNTING OFFICE ISSUED REPORTS WHICH CONCERN THE ELDERLY—Continued

Title	*Date*
Report to the Congress on Information and Referral for People Needing Human Services—A Complex System That Should Be Improved (HRD-77-134).	Mar. 20, 1978.
Letter to Representative Benjamin S. Rosenthal on Review of Certain Operations of Group Health Incorporated Under Part B of Medicare in Queens County, New York (HRD-78-104).	Apr. 11, 1978.
Staff Study on Inconsistencies in Retirement Age: Issues and Implications (PAD-78-24).	Apr. 17, 1978.
Report to the Congress on Effect of the Employment Retirement Income Security Act on the Termination of Single Employer Defined Benefit Pension Plan (HRD-78-90).	Apr. 27, 1978.
Report to the Congress on States Should be Fully Reimbursed for Interim Assistance to Supplemental Security Income Recipients (HRD-77-145).	May 15, 1978.
Letter to Representative John N. Erlenborn on Testing of SSA's Payment Records Before Enactment of Recent Legislation to Determine if Federal Black Lung Benefit Payments Were Correctly Reduced by State Workmen's Compensation Payments (HRD-78-109).	May 16, 1978.
Report to the Secretary, Health, Education, and Welfare, on Review of SSA's Supplemental Security Income Program Concerning Substantial Overpayments to Recipients (HRD-78-113).	May 22, 1978.
Report to the Congress on Supplemental Security Income Quality Assurance System: An Assessment of Its Problems and Potential for Reducing Erroneous Payments (HRD-77-126).	May 23, 1978.
Letter to the Secretary, Health, Education, and Welfare, on Recovery of Overpayments Requirements Under the Aid to Families With Dependent Children Program (HRD-78-117).	May 25, 1978.
Letter to Chairmen, Senate Committee on Finance and House Committee on Ways and Means, on Substantial Overpayments to SSI Recipients Occur Because SSA Determines Eligibility and Benefit Amounts on a Prospective Quarterly Basis (HRD-78-114).	May 26, 1978.
Letter to Chairman, Subcommittee on Oversight and Investigations, House Committee on Interstate and Foreign Commerce, and Representative Anthony Toby Moffett on the Low Medicare Part B Assignment Rates in Connecticut (HRD-78-111).	May 31, 1978.
Report to Representatives Charles Rose and John E. Moss on Procedures to Safeguard Social Security Beneficiary Records Can and Should Be Improved (HRD-78-116).	June 5, 1978.
Report to the Congress on Better Services at Reduced Costs Through an Improved "Personal Care" Program Recommended for Veterans (HRD-78-107).	June 6, 1978.
Report to the Congress on Are Neighborhood Health Centers Providing Services Efficiently and to the Most Needy? (HRD-77-124).	June 20, 1978.
Report to the Congress on Savings Available by Contracting for Medicaid Supplies and Laboratory Services (HRD-78-60).	July 6, 1978.
Report to the Congress on Disability Provisions of Federal and District of Columbia Employment Systems Needs Reform (FPCD-78-48).	July 10, 1978.
Letter to Representative Edward R. Roybal on Questions on Recently Reported Projection of Aliens Receiving Supplemental Security Income Benefits (HRD-78-136).	July 18, 1978.
Letter to the Chief, Health Professional Staff, Senate Committee on Finance, on Survey of Medicare Reimbursement for Return on Investment in For-Profit Hospitals (HRD-78-152).	July 31, 1978.
Letter to the Staff Director, House Select Committee on Aging, on Esimate of the Cost to Implement H.R. 10738, A Bill Liberalizing Home Health Benefits Under Medicare (HR8-188).	Aug. 3, 1978.
Report to the Congress on Replacing Missing SSI Checks—Recipients Waiting Longer Than Necessary (HRD-78-28).	Aug. 22, 1978.

ENCLOSURE 1.—GENERAL ACCOUNTING OFFICE ISSUED REPORTS WHICH CONCERN THE ELDERLY—Continued

Title	*Date*
Letter to the Chairman, Railroad Retirement Board, on Serious Physical Security Deficiencies at RRB's Chicago Headquarters and Steps Taken by the Board to Correct Same (HRD-78-162).	Aug. 29, 1978.
Letter to Chairmen, House Committee on Education and Labor and Senate Committee on Human Resources, on Black Lung Benefit Payments to Widows by SSA Not Reduced When Recipient Also Receives State Workmen's Compensation Payments (HRD-78-157).	Sept. 6, 1978.
Letter to the Chairman, Subcommittee on Social Security, House Committee on Ways and Means, on Savings to Social Security System If Benefits Were Calculated to the Nearest Penny (HRD-78-160).	Sept. 8, 1978.
Report to the Chairman, Permanent Subcommittee on Investigations, Senate Committee on Governmental Affairs, on Attainable Benefits of the Medicaid Management Information System Are Not Being Realized (HRD-78-151).	Sept. 26, 1978.
Report to the Chairman, Subcommittee on Oversight, House Committee on Ways and Means, on Opportunities to Reduce Administrative Costs of Professional Standards Review Organizations (HRD-78-168).	Oct. 12, 1978.
Letter to the Secretary, Health, Education, and Welfare, on Ohio's Medicaid Program: Problems Identified Can Have National Importance (HRD-78-98A).	Oct. 23, 1978.
Report to the Congress on Evaluation of Four Energy Conservation Programs—Fiscal Year 1977 (EMD-78-81).	Nov. 21, 1978.
Letter to the Secretary, Health, Education, and Welfare, on Improvements Needed to Insure the Accuracy of SSI Retroactive Payments (HRD-79-26).	Dec. 11, 1978.
Report to the Congress on Liberal Deposit Requirements of States' Social Security Contributions Adversely Affected Trust Funds (HRD-79-14).	Dec. 18, 1978.
Letter to the Secretary, Health, Education, and Welfare, on Payment Problems and Potential Program Abuses Identified During Examination of Alternatives to Financing Student Benefits Under SSA's Retirement, Survivors, and Disability Insurance Program (HRD-79-27).	Dec. 22, 1978.
Letter to the Chairman, Subcommittee on Transportation and Commerce, House Committee on Interstate and Foreign Commerce, on Comments on 10 Bills to Increase Railroad Retirement Benefits (HRD-79-23).	Dec. 28, 1978.

ENCLOSURE 2.—GENERAL ACCOUNTING OFFICE JOBS IN PROCESS WHICH CONCERN THE ELDERLY

Review of medicare cost reimbursement system for home health care.

Comparison of reimbursement for physicians services under medicare and private health insurance plans of selected carriers.[1]

Review of medicare claims processing system as required by section 12 of Public Law 95-142.

Survey of hospices in the United States.[1]

Review of hospital costs for selected routine supply items.[1]

Review of medicare utilization changes and claimed cost savings by selected professional standards review organization.[1]

Review of medicare and medicaid post payment monitoring system for professional standards review organizations.

Review of Oklahoma's utilization review system.[1]

Review of management of medicaid nursing home patient drug regimens.

Review of federal sharing related to the medicaid program to buy-in medicare beneficiaries.

Review of identification and recovery of medicaid overpayments to providers.

---

[1] Being performed at the request of committees or individual members of Congress.

Survey of the paperwork burden on the elderly.

Review of the compensation by Federal agency of personnel who are other than full-time employees.

Review of the proposed retirement system for military personnel.

Impact of medical policies on nursing home utilization by the elderly.

Survey of Federal efforts to house low income elderly and handicapped.

Survey of Washington Metropolitan Area Transit Authority bus and rail operations.

Survey of the effectiveness of State and area agencies on aging.

Survey of the Administration on Aging model projects program.

Review of ACTION's older American volunteer programs.[1]

Evaluation of four energy conservation programs—fiscal year 1978.

Review of the impact of Federal programs on the elderly.

Review of the delivery of title XX social services to elderly SSI recipients.[1]

Analysis of the well-being of elderly Americans living in rural versus urban areas and in congregate housing.[1]

Survey of the administration of title XX contractors.

Review of SSA's processing of SSI posteligibility changes.[1]

Review of large retroactive windfall payments to SSI recipients.

Review of internal controls and performance of the SSI system.[1]

Survey of SSI payments to recipients residing outside the United States.

Survey of HEW's regulation of residential facilities where SSI recipients reside.

Survey of uncashed SSI, VA pension, and AFDC checks.

Survey of income security programs in the U.S. territories and possessions.

Survey of SSA payments to foreign beneficiaries.

Survey of SSA retirement and survivors insurance program.

Survey of operations at the Railroad Retirement Board.

Review of overpayments from SSA trust funds.

Survey of minimum retirement and survivors insurance benefit payments.

Survey of earnings suspense file and duplicate payments.

Review of alternatives to financing SSA student benefits.

Survey of SSA's management of district offices.

Survey of earnings test.

Review of railroad retirement trust fund.[1]

Review of railroad retirement proposed legislation.[1]

Survey of SSA's program for recovering SSI overpayments.[1]

Review of request by SSA to monitor phone calls in teleservice centers.[1]

Review of security of beneficiary records used by State agencies and outside contractors.[1]

ENCLOSURE 3.—GENERAL ACCOUNTING OFFICE'S INTERNAL ACTIVITIES FOR THE ELDERLY

Equal Employment Opportunity and Merit Promotion, two programs covered by GAO orders, provide the basis for our policy regarding employment of the elderly. From the prohibition of discrimination on the basis of age in employment and in selection for job vacancies, other policies and practices evolve. For instance, because training is important to enhance effectiveness and provide opportunities for advancement, older employees are included in opportunities for training, both in-house and outside the agency.

In keeping with the policy of nondiscrimination, persons over age 40 are recruited for available positions with the Office. Although an employment freeze limited our level of recruitment, 1,067 persons were appointed to permanent and temporary positions during 1978. Of that number, 131 persons (12 percent) were age 40 and older at the time of their appointment.

As of December 31, 1978, 1,800 persons (35 percent of our workforce) age 40 and older were on the rolls of the General Accounting Office. Though employees in this age group participate widely in all our programs, we especially note that we have employees age 40 and older in the upward mobility program (three) and in our cooperative education program (two). These programs usually draw participants from a younger population.

The Employee Health Maintenance Examination, a comprehensive and professional medical examination, is available on a 2-year cycle for all employees age 40 and older. Employees nearing retirement age have available individual preretirement counseling. Our Equal Opportunity Office also provides information and advice to persons regarding complaints of alleged discrimination because of age.

---

[1] Being performed at the request of committees or individual Members of Congress.

ITEM 17. ENVIRONMENTAL PROTECTION AGENCY

JANUARY 15, 1979.

DEAR MR. CHAIRMAN: In response to your letter of December 1, 1978, I am again pleased to report the Environmental Protection Agency's (EPA) sponsorship of job opportunities for the population aged 55 years and over.

On October 18, 1978, the White House hosted a Senior Environmental Employment (SEE) ceremony to commemorate the program's successful first year, and to honor the SEE participants, national contractors, State grantees, and national project coordinators.

This event was the high point of a year in which President Carter designated May as Older Americans Month, and EPA declared May 24 as Senior Environmental Employment Day. Also on October 18, President Carter signed the reauthorization bill for the Older Americans Act. This legislation provided a considerable boost to the Senior Environmental Employment Program by specifically citing SEE as a good resource for the country and by authorizing its expansion into all 50 States. EPA feels that this citation is due, at least in part, to the results of an Administration on Aging funded comprehensive evaluation of the program's first year of operation.

The Foundation for Applied Research—the organization conducting the evaluation—said in its final conclusions that:

"At the end of the initial year of operation, the Senior Environmental Employment Program is evaluated by the Foundation for Applied Research to be a major success. The concept of utilizing older workers in projects to improve and protect the environment has been shown to be valid. This was true within a variety of types of projects and tasks, with workers of a wide variety of educational and occupational backgrounds, and in a wide variety of administrative relationships. The first year experiences of the SEE program provides a strong foundation for further research and expansion."

Since the program has begun, it has provided meaningful part-time employment to over 200 older Americans in jobs relating to the prevention, abatement, and control of environmental pollution. The jobs include surveying toxic chemicals used in industrial areas, educating the public on areawide water quality planning, educationing the public on programs in noise abatement, establishing and managing agency environmental libraries, presenting educational programs on the uses of pesticides and the hazards of poisoning to farm workers, and working on surveys of environmental carcinogens.

The effectiveness of using senior citizens for environmental jobs was proven in an earlier program. Some 72 older Americans were employed to conduct a Pesticides Inventory Program in the State of Iowa with great success. Their activities included product processing, registrations, reporting pesticide accidents, and developing a general statewide awareness of the dangers of misusing pesticides. The project was quite unique in that it involved cooperation and support of several organizations such as the State Agriculture Department, Commission on Environmental Quality, Commission on Aging, National Retired Teachers Association, American Association of Retired Persons, Iowa Public Community College System, and the Department of Labor.

The pilot programs are presently funded through August 1979 with a strength of approximately 220 older workers. Some of the enrollees have been hired by the agencies as a regular employees. Typical responses to the activities of the SEE program are:

> "This program could very well prove to be one of the better ways to tackle environmental problems."—Richard F. Kneip, Governor, South Dakota.
>
> "We feel the concept utilized in the SEE program has valid application in the abatement of other forms of environmental pollution. We feel that legislation to create a Federal Senior Employment Corps would enable the U.S. Environmental Protection Agency and the Administration on Aging to work together productively toward the control of many environmental hazards now imposed on our society."—Janet J. Levey, director, California Department of Aging.

The EPA has been a good Federal organization to pilot this effort. EPA currently administers Federal legislation designed to control, reduce, and eliminate pollution in the areas of air, water supply, wastewater, solid waste, noise, pesticides, radiation, and toxic substances. Aside from its regulatory and enforcement functions, EPA provides technical and financial assistance to public and private agencies at all levels in support of pollution control and abatement programs and projects. A major concern in pollution control is the availability of qualified personnel at all levels to carry out the responsibilities mandated by Federal, State, and local environmental agencies. Moreover, environmental control activities have a relatively high potential for permanent unsubsidized employment in State and local government and in the private sector, especially in the subprofessional/technical occupations.

EPA is working to expand SEE into all eight environmental program areas. We believe that this program can be adapted easily to suit the needs of every State in meeting legislative mandates. Expanding SEE will provide an opportunity for many more older citizens to participate in and benefit from the program while improving the quality of life in general.

Sincerely yours,

DOUGLAS M. COSTLE,
Administrator.

Enclosure.

COST-BENEFIT ANALYSIS

COST-BENEFIT ANALYSIS OF MANPOWER PROGRAMS: A BRIEF SUMMARY AND CRITIQUE

Cost-benefit analysis is a practical methodology for choosing between expenditure proposals when the private market cannot make a satisfactory choice. It is most commonly employed for investment decisions in the public sector of the economy. Here, the market cannot provide an efficient allocation of investment either because the good or service is characterized by significant externalities, it has a zero or declining marginal cost, or it is to be supplied at zero price because of various socio-political objectives.

Advocates of cost-benefit analysis believe that this methodology can be a powerful tool for increasing the efficiency of resources used in government manpower program administrators have employed the technique to answer questions such as the following: (1) Should a particular program currently operating be continued, (2) which of several ongoing programs should be expanded or cut back, (3) how should the components of a specific program be modified to increase efficiency, and (4) what programs are best suited to the needs of particular groups of individuals.

Cost-benefit studies of manpower training programs have generally employed one of two major techniques for quantifying program benefits. The simplest approch is to compare the pre- and post-training incomes or wage rates of the program participants. A better method is to compare the before-and-after trainee incomes with those of a scientifically selected control group. An ideal control group would enable the investigator to measure the amount of trainee benefits attributable to the training itself.

The enchantment of earning power is not the only benefit derived from training programs. The monetary value of trainee output, if any, is occasionally incorporated into the benefit measure. Society as a whole may gain from such programs (e.g., through reduction in crime or illness), and the trainees may reap psychological benefits in ways that cannot be readily translated into specific dollar values.

The costs of manpower training programs are usually taken to be the training and administrative costs of the government. Enrollee stipends and contributions from private employers may also be included in certain cases.

Some writers state that cost-benefit analysis gives explicit recognition solely to those benefits that can be assigned monetary values. Other, noneconomic criteria for measuring program effectiveness (e.g., the percentage of persons completing a training program who obtain jobs utilizing skills in which they were trained) may be considered but are not injected into the formal benefit computations. When such "effectiveness" measures do form an integral part of the cost-benefit calculus, the technique may then be termed "cost-effectiveness" analysis. As with cost-benefit analysis, program comparisons are commonly made by means of an effectiveness-cost or a cost-effectiveness ratio.

The application of cost-benefit and cost-effectiveness analysis to government manpower programs over the past 15 years has produced highly variable results.

Most of these studies utilize the cost-benefit approach. The benefit-cost ratios obtained run the gamut from less than zero to well over 100. Even within individual manpower programs, the variation is quite large. An Urban Institute study published in 1973 cites an average (weighted) benefit-cost ratio of 3.8 for all projects in the Concentrated Employment Program (CEP). On a project-by-project basis, however, the ratios exhibit a very broad range—from 2.3 to 15.8. For a sample of Manpower Development and Training Act (MDTA) institutional training projects, the benefit-cost ratios were found to vary from −0.6 to +21, with an average of 2.1.

What accounts for such diverse results? In the first place, there is a considerable difference of opinion as to what constitutes cost and benefit. Definitions vary so much from study to study that separate evaluations employing the same data may yield vastly different benefit cost ratios. A second major problem is inadequate data. The data collected often do not convey a true impression of the average or typical impact of the program under evaluation. Measurement techniques and sampling strategies differ among studies and inject unmeasurable biases into the cost-benefit calculations.

Of course, it should be stressed that the manpower programs themselves exhibit a kaleidoscopic heterogeneity in terms of real cost and effectiveness. They involve different objectives, target groups, geographic settings, and local economic conditions. And a given program may change markedly over time, so that a one-shot study does not necessarily provide an accurate longitudinal picture of program costs and benefits.

Cost benefit and cost-effectiveness techniques are best suited for the evaluation of one single project or a set of similar projects within a specific program. However, such studies have not been routinely included in manpower program evaluations. When cost-benefit analyses are performed, the results are usually considered valid only when they present a favorable image of the program. In the case of programs that have been terminated because of a low benefit-cost ratio, the evaluation often turns out to be a rationalization for a decision already made.

Cost-benefit studies have thus had a rather limited impact on the formulation of government manpower policy. This, coupled with the bewildering variety of results that one encounters in the empirical literature, has led in recent years to a notable decline in the popularity of cost-benefit analysis as a strategy for manpower program evaluation.

COST-BENEFIT ANALYSIS OF SEE PROGRAM

The approach taken by FAR to the cost-benefit aspect of the evaluation of the AoA-EPA SEE program is straightforward. The cost-benefit analysis is applied to the program as a whole, rather than to each state program individually.

Measurement of Costs

The cost of the SEE program for the first year within the selected states is measured as the sum of the budget provided by AoA and the total contributions of the grantees. Costs of designing, launching and evaluating the demonstration program are not included as they would not be ongoing costs of a permanent program. It is recognized that the administrative overhead costs of this demonstration program can be expected to be substantially greater than the administrative overhead costs of a larger, ongoing program which might grow out of the demonstration project. A demonstration program such as this has additional overhead costs generated by startup costs, heavy initial training expenses, and relatively low economies of scale. An ongoing program 10 times the size should cost well under 10 times as much.

Measurement of Benefits

There are two categories of benefits of the SEE program. The first is the set of benefits produced by the positive impact of the activities of SEE workers on the quality of the environment. It is beyond the scope of this evaluation to attempt to measure directly the impact of SEE workers on the environment (e.g., how much cleaner the water in Pennsylvania has become as a result of that State's SEE project). Further, even if such direct measures were feasible, the diversity of state projects would preclude a meaningful summary measure of environmental impact.

FAR has measured indirectly the impact of the SEE program on the environment by asking EPA officials managing the individual State projects to estimate the costs of duplicating the efforts of the SEE workers with regular full-time personnel. The number of full-time workers needed to perform the functions of the SEE workers times their salaries-plus-fringe benefits, plus other costs (travel, etc.), has provided a proxy, measured in dollars, for the impact of SEE workers on the quality of the environment.

The benefits of the SEE program accruing to the SEE workers themselves—increased happiness, self-esteem, social participation—are not readily translatable into dollars. FAR has not attempted to do so. These benefits have been measured directly through a series of surveys of the workers. They are reported in chapter II and are briefly summarized in this section.

The above approach does not provide the traditional cost-benefit ratio. For reasons already noted, such as the relatively high overhead of a demonstration program and the difficulty of translating worker benefits into dollar figures, this would be inappropriate. However, it does provide an indirect dollar measure of the impact of SEE workers on the environment and a measure of the benefits to the older workers themselves.

The Costs

The cost of the SEE program is measured by the sum of the budget provided by AoA ($1,000,000) and the total contribution of the grantees ($120,708). This amounts to a total program cost of $1,120,708.

The Benefits to the Environment

There is no practical way to measure directly the impact of the SEE workers on the environment. Therefore, we have measured the dollar value of the impact of SEE workers on the environment by totaling the estimated costs of the 10 States duplicating the work of the SEE workers by using regular full-time personnel, taking into account any productivity differences. This amounted to $1,341,057. Thus, $1,341,057 of environmental benefits were obtained for a cost of $1,120,708, for a net saving of $220,349 or 10.4 percent.

The Benefits to the Workers

The benefits to the individual worker of participating in the SEE program are analyzed in detail in chapter II. Three-quarters of the SEE workers reported that their lives had improved as a result of SEE participation. Most of these viewed the primary source of improvement in terms of increased self-esteem and interest in life. For some SEE workers the impact of participation was dramatically positive, resulting in a major improvement in well-being.

In addition to the environmental benefits and the benefits to the workers, the SEE program has had other important positive impacts. One of these is an increased appreciation by supervisors and administrators in the environmental field for the potential contribution of older workers. More generally, the success of the SEE program is adding significantly to the body of evidence that older Americans, male and female, of various educational and occupational backgrounds, constitute a vital and underutilized supply of labor which our society cannot afford to overlook.

Summary

The above can be summarized in the form of a cost-benefit statement. For a cost of $1,120,708, the SEE program produced the following benefits:

(1) Work in the environmental field which would have cost $1,341,057 if done by regular full-time workers (and which in many cases would not have been done at all).

(2) Improvement in the lives of at least 125 older Americans and great improvement in the lives of at least 60 of these.

(3) Indirectly, greater employment opportunities for other older Americans and an increased utilization of the contributions of which such older persons are capable.

CONCLUSIONS AND RECOMMENDATIONS

At the end of the initial year of operation, the Senior Environmental Employment Program is evaluated by the Foundation for Applied Research to be a major success. The concept of utilizing older workers in projects to improve and protect the environment has been shown to be valid. This was true in a variety of types of projects, within a variety of types of tasks, with workers of a wide variety of educational and occupational backgrounds, and in a wide variety of administrative relationships.

The first-year experience of the SEE program provides a strong foundation for further research. FAR presents the following recommendations:

CENTRAL RECOMMENDATIONS

(1) The SEE program should be expanded.—The success of the demonstration project warrants expansion (1) to all fifty States, and (2) within states already having SEE programs. Such expansion should be made carefully and incrementally. States currently without SEE projects should begin with projects of the same scale as current projects (15 to 20 workers).

(2) Explore other potential utilizations of older workers in public service.—Expansion of the SEE concept need not be limited to the environmental field (though obviously there is great potential there). The fields of public health, consumer protection, recreation and social services hold great promise for development of SEE-type programs.

(3) Publicize the success of the SEE program.—FARs research indicates that many state environmental employees were at first skeptical regarding the potential contributions of SEE workers but after experience with the program are almost unanimous in strong praise of the workers. Successful expansion of the SEE program depends upon the dissemination of positive findings to environmental agencies not currently involved with the SEE project, other government agencies which might develop SEE-type programs, agencies on aging, older persons, and the general public.

AUXILIARY RECOMMENDATIONS

(1) Explore the possibility of waiving, raising or otherwise ameliorating the social security earnings limitations for SEE workers and other low-wage public service workers. This limitation has been a problem for a significant number of SEE employees.

(2) Extend channels of communication within the SEE Program, especially inter-project communication, via newsletters, slide shows, conferences, etc.

(3) Explore means of reducing the expense (or increasing the reimbursement) of SEE workers' use of their own automobiles for performance of job duties. Increased insurance costs in particular are a problem.

(4) Explore the possibility of a federally sponsored health care/hospitalization program for SEE workers (and other older workers in public service). Lack of such a program has been a problem for a substantial number of SEE workers.

(5) Insure in any new SEE programs undertaken that the sponsoring state organization has direct program responsibility for the projects in which the SEE workers are to engage.

(6) Provide orientation and informational materials to state officials who are considering sponsoring SEE programs in the future in order that they fully understand the successes of other programs and the potential contributions of SEE workers.

ITEM 18. FEDERAL COMMUNICATIONS COMMISSION

JANUARY 16, 1979.

DEAR MR. CHAIRMAN: Your letter of December 1, 1978, requesting information concerning any actions or programs relating to aging which this Commission may have engaged in since 1977, sought material for inclusion in part II of your committee's next periodic report of "Developments in Aging," scheduled for publication in February of 1979.

This Commission does not have any direct responsibilities with respect to the problems of aging or the elderly and did not have any programs or take any actions directly concerned with aging or the elderly. I was asked by Congressman Pepper's counterpart House Select Committee on Aging to submit views on the subject of "Age Stereotyping and Television" and related topics; a copy of my response to Chairman Pepper, dated January 5, 1978, is enclosed. As you will see from that response, I declined to appear as a witness because of first amendment considerations and a statutory prohibition on Commission censorship of programing that limit the Commission's actions in the area of programing.

The response to Chairman Pepper explains in greater detail the extent of and limitations on the Commission's concern with program content. You may wish to consider whether this material is suitable for your committee's report. Thank you for the opportunity to participate in the work of your committee.

Sincerely yours,

CHARLES D. FERRIS, *Chairman.*

Enclosure.

FEDERAL COMMUNICATIONS COMMISSION,
Washington, D.C., January 5, 1978.

Hon. CLAUDE PEPPER,
Chairman, Select Committee on Aging,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: I have your recent letter inviting me to testify at a hearing on January 25, 1978, before your Select Committee on Aging on the subject "Age Stereotyping and Television." For reasons more fully explained below, I believe it would be inappropriate for me to appear as a witness in this hearing. Initially, the subject matter of your hearing involves programing, an area which enjoys the constitutional protection of the first amendment guaranteeing free speech. In addition, the Commission is prohibited by law from censoring broadcast matter and from taking any action which would interfere with the right of free speech by broadcasting. The Commission looks to the licensee, as a public trustee, to assume the responsibility for the selection of programing based on what he has learned in ascertaining the problems and needs of the community to which his station is licensed.

In its policy statement on ascertainment, the Commission stated that ". . . the principal ingredient of the licensee's obligation to operate his station in the public interest is the diligent, positive and continuing effort . . . to discover service area." *Statement of Policy Re: Commission En Banc Programming Inquiry,* 25 Fed. Reg. 7291, 20 RR 1901 (1960). In the fulfillment of this obligation, the licensee must consult with leaders who represent the interests of the community and members of the general public. Community leaders should represent a cross section of those who speak for the interests of the service area. This cross section includes, among many others, organizations of and for the elderly. *Ascertainment of Community Problems by Broadcast Applicants—Primer,* 41 Fed. Reg. 1381 (copy enclosed).

The program material presented on television generally enjoys the constitutional guarantees of free speech, even if it may be offensive to some viewers. Thus, the Commission must rely on the good taste and responsible judgment of broadcast licensees to assure broadcast of material that would not tend to stereotype, demean, or degrade any group in the society, religious, racial, ethnic or other group including the elderly. In response to any complaints the Commission receives about programing, we urge viewers to make their concerns known directly to the stations and networks involved. In that way, the licensees are better able to exercise their professional judgment with respect to programing broadcast in their communities.

We have found in our experience that most responsible broadcasters are interested in receiving from the various elements within their service areas suggestions on programing to meet specified needs and interests. This, coupled with their own ascertainment efforts, enables them to provide a service designed to meet the needs, interests and problems of the service area. Representatives of the elderly in a community, who wish to see increased programing on topics of serious concern to the elderly, should address their suggestions to the stations and networks serving the area.

In response to other questions posed in your letter, you should be advised that at the present time no station has lost its license because it failed to respond to the concerns of the elderly in a community. In addition, we are unable to comment on whether age stereotyping on television is a problem since the Commission does not routinely monitor the content or qualitative aspects of individual television programs. I might add that our records further reveal that the Commission has received very few complaints concerning this subject.

As to your last question, asking whether the Commission would favor or oppose regulation as a means of minimizing age stereotyping on television, I can only say that such programing, though it may be viewed as—an in fact be—offensive or demeaning, falls within the protection of the first amendment. Thus, as we have already emphasized, the Commission and the public must look to the networks and station licensees to exercise responsible judgment in making programing determinations.

I trust that you will find the above information helpful. Should you have need for any additional information, please let me know.

Sincerely,

CHARLES D. FERRIS, *Chairman.*

ITEM 19. FEDERAL TRADE COMMISSION

JANUARY 22, 1979.

DEAR MR. CHAIRMAN: The Federal Trade Commission is pleased to respond to your request for a report on our actions and programs related to aging during the past year. As you know, the responsibilities of the Federal Trade Commission include the protection of consumers from commercial abuses and the enforcement of antitrust laws. Many of these activities do, we believe, result in a more competitive and fairer commercial environment and this should be of particular benefit to older people, especially those who must live on a fixed income, enclosed is a staff summary of Commission activities during 1978 which particularly impact older Americans.

In reviewing the list of Commission activities, I think you will find that the Federal Trade Commission is deeply committed to helping elderly persons. We appreciate the opportunity to assist the committee in its work and we hope you will call on us if we can help in any other way.

By direction of the Commission.

MICHAEL PERTSCHUK, *Chairman.*

Enclosure.

STAFF SUMMARY OF FEDERAL TRADE COMMISSION PROGRAMS RELATED TO AGING

(1) NURSING HOME INVESTIGATION

The Commission is currently investigating alleged economic abuses in the nursing home industry. Nearly 1.2 million people reside in the Nation's 24,000 nursing homes. The staff is particularly concerned about a number of practices, including:

Contract provisions which absolve the home from financial liability for injury to the patient or theft of the patient's property.

Prohibitions which prevent the patient or family members from buying supplies on the open market with the result that they must pay inflated prices.

Contract provisions requiring the patient's guarantor to waive all rights to be informed of changes in the terms of the patient's care or in charges. As a result the guarantor may be required to pay for services not knowing in advance what those services are or how much they cost.

Contract provisions requiring the guarantor, if he sues the home, to pay all costs of litigation, even the fee for the nursing home's attorney.

Failure to disclose to a patient before entering a home what behavior or financial condition will precipitate eviction.

Life care contracts which require the patient to turn over all assets as a condition of admission without an opportunity to cancel after a reasonable period of time.

Possible remedies under active consideration by staff as part of a possible trade regulation rule include:

Requiring nursing homes to disclose all pertinent information about charges and fees, termination policies, and refund practices.

Prohibiting possibly unfair safety, theft, and waiver clauses in admissions contracts, and other one-sided contract provisions, like requiring the guarantor to pay all costs of litigation against the home.

Requiring that life-care contracts include a 60-day trial period.

Allowing patients and their families freedom of choice to purchase supplies on the open market.

(2) BLUE SHIELD ANTITRUST INVESTIGATION

The Commission continued its antitrust investigation of Blue Shield in 1978 and the Commission staff expects to make its recommendation to the Commission in the near future. That investigation concerns alleged physician control of the 71 Blue Shield plans and the Blue Shield Association. The investigation is examining the nature and extent of physician control of the Blue Shield organizations and its impact on competition in the delivery of health care.

According to the staff investigation, approximately 40 percent of the population pays for physician services through Blue Shield. In 1976, Blue Shield plans paid out about $6.5 billion, including $4 billion from consumer premiums and $2.5 billion from Federal funds. Thus, their policies and practices may significantly affect fee levels and other forms of competition in the provision of health care.

(3) PROPOSED TRADE REGULATION RULE ON FUNERAL PRACTICES

The Commission is now considering the proposal of its staff that it issue a trade regulation rule concerning funeral practices. After an extensive rulemaking proceeding lasting several years and, based on an analysis of the 45,000-page record, the staff believes that bereaved relatives are frequently denied price and other basic information necessary for an informed choice and that regulations are necessary to curb certain abuses at funeral homes. The staff estimates that many of the 2 million people who purchase funerals every year will be able to save $200 to $1,000 through use of information provided by operation of the proposed rule.

The rule recommended by the staff would require that, before making a selection, the purchaser be furnished with price lists for caskets and burial containers (such as vaults or grave liners) and a general price list itemizing amounts for funeral service and merchandise and also stating that embalming may not be done without permission. The purchaser also would later have to be given an itemized agreement listing the prices of the merchandise and services that were selected.

To ensure that consumers can make informed decisions and comparison shop if they desire, the rule would require that funeral directors quote prices over the phone, and send a copy of the general price list upon request and include in advertisements a notice that price information is available over the telephone. The staff's proposed rule also contains provisions that would prohibit misrepresentations and other deceptions by funeral directors.

The Commission has not yet decided whether, or in what form, to issue a regulation. That decision will be based upon a review of the entire record, including the staff's report, the presiding officer's report and any public comments on the reports.

(4) STUDY OF MEDICARE SUPPLEMENT INSURANCE

The Commission has released a staff issues paper on Medicare supplement insurance (or "Medigap") in response to allegations of various abuses in sales of these policies to the elderly. It has been alleged that some agents sell several policies with overlapping, worthless coverage to the same person; this is called "stacking." Allegedly, agents' sales pitches sometimes represent that a policyholder's current coverage is inadequate and that extra policies will fill the gaps. Another alleged marketing abuse is "twisting," or persuading people to cancel their policies and buy new ones which subject them to new exclusions and waiting periods.

Agents may have an incentive to engage in overselling and twisting because they typically receive high first year commissions on Medigap policies; a 65 percent commission is routine, and a 100 percent first year commission has been reported.

Consumers have so little information about medicare supplement policies that it is almost impossible for them to make rational purchase decisions. This lack of information may, in turn, facilitate agent misrepresentations about unstandardized policies.

The variety of differing policies makes it extremely difficult for buyers to compare benefits and premiums. As a result companies are not forced to compete on price and many offer policyholders only a very low return.

State regulations of medicare supplement insurance differ widely, and the FTC has recommended that an impact evaluation study be performed to determine their relative effectiveness. Such an evaluation could assess the strengths and weaknesses of each State's system. To aid in the design of a full-scale impact evaluation, the FTC has contracted with an organization to perform a preliminary methodology study. This design-phase project will involve preparation and pretesting of survey instruments for use with both industry and consumers.

An FTC staff member is also serving on the advisory committee to the National Association of Insurance Commissioners' task force on medicare supplement insurance.

(5) PROPOSED TRADE REGULATION RULE ON HEARING AIDS

The Commission is now considering a staff proposal that the FTC issue regulations designed to curb abuses in the sales of hearing aids. In the staff's report on the proposed rule, which was issued on November 19, 1978, after a rulemaking proceeding lasting several years, the staff noted evidence of numerous abusive selling techniques in the hearing aid industry.

For example, the staff report says some retailers sell used hearing aids as new. In addition, some sellers represent that hearing aids will function in a manner similar to the way a normal ear functions or claim that hearing aids will retard or arrest the progression of hearing loss when such is not possible.

Under terms of the recommended rule, the buyer may invoke a 30-day right to return the hearing aid if the hearing aid is unsatisfactory in any way. If the buyer exercises that right, he would be entitled to most of his money back. The recommended rule would permit the seller to retain specified cancellation charges amounting to $50 for each hearing aid returned.

The recommended rule would also restrict the manner in which prospective hearing aid customers could be obtained. In addition, it would provide consumers with protection against unsolicited and unannounced sales visits at their homes or places of employment. People selling hearing aids would be required to identify themselves as sales persons under terms of the proposed rule. According to the staff, the record indicates that many people selling hearing aids represent themselves as "experts" to prospective customers. Under terms of the recommended rule, misleading advertising and misrepresentations by sellers would be prohibited and high pressure sales tactics would be discouraged. The recommended rule would require all hearing aid sellers to give each buyer certain simply worded documents which clearly spell out the buyer's right to return the hearing aid within 30 days of delivery. In addition, the seller is required to state orally that the hearing aid may be returned. If these documents are not given to the buyer, or if there are oral misrepresentations by the seller, the FTC can impose civil penalties on the seller.

Of the estimated 650,000 hearing aids purchased annually in the United States, most are bought without the involvement of a medical specialist. About half of all such sales are consummated in the consumer's home. It is in such cases that many abuses take place, according to the FTC staff.

The Commission has not yet decided whether, or in what form, to issue a regulation. That decision will be based on a review of the entire record, including the staff's report, the presiding officer's report, and any public comments on the reports.

(6) STUDY OF GENERIC DRUG SUBSTITUTION LAWS

The FTC has just released a staff study of generic drug substitution. That study indicates that consumers could save hundreds of millions of dollars in prescription drug costs if the marketplace fostered the purchase of the lowest-cost generic equivalent. We believe that the lack of price competition in this market has been caused in part by State laws preventing pharmacists from substituting less expensive generics.

Along with the staff study, the FTC released jointly with HEW a model generic drug substitution law for the States. About 40 States do now permit some form of pharmacist selection of generic rather than brand-name drugs. The State laws, however, vary greatly in their potential effectiveness; indeed some "substitution" laws impose so many burdens and restrictions on the substituting pharmacist that substitution simply does not take place.

Because the States are currently in a period of transition, it may be too early to enact preemptive Federal legislation, particularly in light of the likely costs of Federal enforcement. A better approach, at this stage, we believe, would be to observe and evaluate the States' efforts to enforce their laws through the pharmaceutical regulatory bodies and mechanisms already at their disposal. At the same time, the FTC will continue to monitor carefully the success of substitution, and stand ready to take whatever action is necessary to ensure the health of price competition in the prescription drug market.

(7) TRADE REGULATION RULE CONCERNING EYEGLASSES

On July 13, 1978, a trade regulation rule issued by the FTC went into effect for the ophthalmic goods industry (eyeglasses and contact lenses). The rule removes virtually all public and private restraints on the advertising of price and availability of eye examinations and prescription lenses. It also requires that consumers have a right to receive a copy of their prescription when corrective lenses are called for. The purpose of this rule is to promote the flow of information to consumers and to allow them to shop around more effectively.

The Commission believes that this regulation will significantly increase the amount of price competition for prescription eyeware and should substantially reduce prices. As 93 percent of those over 65 use some form of corrective eyeware, this should be of particular value to older persons. In 1975, consumers spent over $4.1 billion in this industry and various surveys have shown that prices of eyeware vary by as much as 100 percent to 300 percent from seller to seller. Several analytical studies have indicated that prices in states where advertising is permitted are 25 percent to 40 percent lower than where advertising is not allowed. The Commission staff has estimated that the savings to consumers as a result of this regulation could range from $250 to $400 million.

(8) STUDY OF "INDUSTRIAL" INSURANCE

The FTC staff is conducting a preliminary study of "industrial" insurance and plans a more detailed study. Industrial insurance consists of small policies (usually under $1,000) sold door-to-door, mostly to low-income persons. Premiums are due monthly or weekly and generally are collected by the agent at the policyholder's home. Most "industrial" insurance is "permanent" (or "whole life") insurance, but some health, accident and fire is also sold.

"Industrial" premiums in 1977 were about $1.3 billion, with approximately 101 million policies in force. While "industrial" insurance is sold to people of all ages, "industrial" policyholders are disproportionately elderly females when compared to other policyholders. In 1977, 61.7 percent of "industrial" insureds were over 69 at age of death and 62.1 percent of claims were made on policies which had been owned for 30 years or more. Because premiums on these old policies are based on how outmoded interest and mortality assumptions unfavorable to policyholders, these elderly policyholders have probably paid very high costs over many years, for relatively small benefits.

The FTC is preparing a preliminary staff issues paper which examines allegations that "industrial" insurance is typically high-cost insurance which provides little relative value for purchasers. This problem may be caused by the lack of consumer information about the costs and benefits of "industrial" insurance relative to alternatives. It also reviews allegations of unfair sales techniques used for this kind of insurance. We expect that this staff issues paper will be released in the near future.

ITEM 20. NATIONAL ACADEMY OF SCIENCES

MARCH 19, 1979.

DEAR SENATOR CHILES: This is in response to your letter of December 1, 1978 and more recent discussion by telephone with your staff concerning preparation of the committee's annual report summarizing Federal programs related to aging. As was indicated, the National Academy of Sciences is a private, nonprofit institution that was created by act of Congress in 1863 to provide advice to the Federal Government on matters of science and related technology. Academy programs that relate to aging are located in the National Research Council and the Institute of Medicine.

In response to a 1977 request from the National Institute on Aging, a committee on Aging was established within the NRC's Assembly of Social and Behavioral Sciences (ABASS) to provide assistance to that institute in developing its

research plans, including the stimulation of high-quality research on topics not yet receiving major attention, and to encourage behavioral and social scientists to participate in research and discussions on these topics. Workshops are planned by the committee dealing with stability and conflict in the elderly family, with the new elderly (those who will be 65 or over in the next several decades), and with biology and behavior. These projects are to provide support on behalf of the 1979 White House Conference on the Family. Recently the Administration on Aging has asked that the NRC assist in developing options on manpower policy for the aging and to conduct assessments of needs measured against such policies. These tasks also are a responsibility of ABASS.

The Institute of Medicine, in the exercise of its responsibilities for identifying issues of medical care, research and education recently completed a study concerning aging and medical education. This study was financed by the National Institute on Aging and grew out of concern emerging from the 1976 Anglo-American Conference on the Care of the Elderly, sponsored jointly by the Institute of Medicine and the Royal Society of Medicine. The major concern of the study dealt with an investigation of the effectiveness with which knowledge of aging is currently being incorporated in medical education. A report was issued on this study in September 1978.

It should be noted that these projects are integral components of the research programs of the respective Federal agencies who sponsor the projects and are likely to be referenced more generally in their reports to your committee.

If we may be of further assistance to your committee, please do not hesitate to call upon me.

Sincerely yours,

PHILIP HANDLER, ***President.***

ITEM 21. NATIONAL ENDOWMENT FOR THE ARTS

JANUARY 12, 1979.

DEAR MR. CHAIRMAN: I am pleased to report to you on the fiscal year 1978 activities of the National Endowment for the Arts related to the programs for older adults.

Enclosed is a summary of the Endowment's activities specifically related to older persons. Of course, all Endowment grantees are encouraged to include all segments of the population in their programs, regardless of age. Perhaps the most important factor which I have become aware of since I became Chairman of the Endowment a little over a year ago is that there is a great deal of new interest on the part of administrators of arts and aging programs, alike, as to how the arts can be made available to older persons. This bodes well for both fields, particularly in view of the Commission on Civil Rights' report several months ago concerning age discrimination.

I trust this information will be useful to you in completing your annual report to Congress. Please let me know if I can be of further assistance.

Sincerely,

LIVINGSTON L. BIDDLE, JR.,
Chairman.

Enclosures.

SUMMARY OF ACTIVITIES RELATING TO OLDER ADULTS, FISCAL YEAR 1978

The National Endowment for the Arts believes that the arts should be made available to as many people as possible. In pursuing this goal, the Endowment has a coordinator of special constituencies who is responsible for advocacy efforts related to older adults, disabled and institutionalized populations. The coordinator also provides information and technical assistance to organizations dealing with arts and aging programs which seek to develop cultural opportunities for older adults.

Through its office of special constituencies and its grant programs, the Arts Endowment is actively engaged in making the arts more accessible in the firm belief that the arts are catalysts for vitalization and enrichment of all individuals, regardless of age. Our advocacy program for special constituencies includes: (1) determining what arts programs already exist for them; (2) advocating more support for addressing their needs through the Endowment's programs and

those of other Federal agencies; (3) recommending ways in which the Endowment can ensure that the arts are made more widely available to them; and, (4) providing technical assistance to individuals and organizations seeking information and assistance in developing arts programs.

Regrettably, attitudinal and policy barriers which hamper efforts to provide creative experiences for older adults continue to persist. Many administrators in the field of aging do not yet understand how the arts can stimulate mental growth, foster self-confidence, and provide opportunities for intergenerational learning.

Last March, I submitted congressional testimony on the reauthorization of the Older Americans Act. In my statement, I said: "The National Endowment for the Arts supports the premise that ageism has no place in our society. We have begun a campaign to sensitize cultural institutions and our colleagues in the arts to ways then can include both frail and independent older persons in arts programs and services designed to play an effective role in modifying long-held attitudes about the aged."

Each year, we continue to see a greater sensitivity among administrators of both arts and aging programs to how the arts can relate to older persons. Largely this is a result of more artists and arts organizations recognizing not only the value of developing older persons as audiences for the arts, but also the tremendous creativity and sensitivity they bring to the arts. By next year at this time, I should hope to be able to report to you that the number of Endowment programs involving older persons has increased significantly.

Endowment support to the National Council on Aging's Center on Arts and the Aging helped it sponsor the second of its nationwide conferences on arts and aging. This conference which took place in January 1978, in Lexington, Ky., was devoted to exploring arts education opportunities for older adults. The proceedings from this conference will be available shortly, and I will be certain that you receive a copy. The older adults participating in the Lexington conference testified strongly to the value of the arts in their daily lives and supported the Endowment's premise that arts programs and services are a major force in reintegrating older adults into society.

Endowment support has also helped the center sponsor three regional training seminars designed to expose practitioners of arts and aging programs to each other and to foster dialogues between them. These seminars were responsive to the interests and needs of managers of arts and aging programs in each particular geographic region and were aimed at orienting them to opportunities for mutual collaboration. The center continues to be a valuable national information clearing house and an effective technical assistance resource. Mrs. Jacqueline Sunderland, the executive director of the center, is an experienced and knowledgeable advocate for arts programming for older adults. Through her commitment and energy the center will be developing a stronger publications component in the next fiscal year. These publications will enable the center to disseminate its technical assistance, expertise, and knowledge of viable arts projects to larger numbers of organizations dealing with arts and aging programs.

ARCHITECTURAL ACCESSIBILITY

Although the majority of older persons are not physically handicapped, many suffer from physical impairments which make it difficult for them to enjoy cultural activities. Often, they may be prevented or discouraged from participating in an event because of architectural barriers within or at the entrance of concert halls, museums, theatres or other arts centers.

The Arts Endowment has continued to support the National Arts and Handicapped Information Service which provides technical assistance and information to organizations concerned with making the arts accessible to disabled persons. The service publishes materials which illustrate how architectural and program barriers can be eliminated.

This year the Arts Endowment convened artists, arts administrators, representatives from arts and cultural institutions, and handicapped consumers to assess the impact of Federal regulations for implementing section 504 of the 1973 Rehabilitation Act concerning elimination of discrimination toward the handicapped. The work of this task force and the expertise of the National Arts and Handicapped Information Service are making the arts organizations more aware of existing barriers. These new regulations and the sensitivity they will develop will result in access to more cultural activities by physically and mentally impaired individuals.

During fiscal year 1978, the Endowment provided design project fellowships through the architecture, planning, and design program to enable research and development of a resource compendium of information on architectural and building products appropriate for use in environments where older adults reside. Through the architecture program's design and communication category, a grant was made to support a special issue of the "Journal of Architectural Education" on design and older adults. I am enclosing a copy of this timely publication for your perusal.

FINANCIAL BARRIERS

Economic factors often are a major cause for lack of participation in arts activities by older persons. The cost of tickets to cultural events, as well as the cost of transportation, discourages attendance by those who live on limited incomes. Various arts organizations have received funds from the Endowment to help them provide tickets at reduced rates or schedule cultural activities where transportation would not pose a problem:

Concerto soloists of Phildelphia has developed a program which includes low-cost tickets to senior citizens and the disadvantaged, and a series of informal concerts given during Sunday afternoons, a time which is safe and convenient for older adults to attend.

The Minnesota Orchestral Association in Minneapolis gave a series of outdoor concerts in area parks and plazas, and two free concerts in Orchestra Hall to senior citizens and handicapped persons.

St. Paul Chamber Orchestra Society has continued to provide half-price tickets to students and senior adults for all orchestra programs. They also offer our morning concerts for nonworking individuals who are reluctant to travel at night.

The Greater Fall River Recreation Committee, Inc., has continued a street theatre project which includes several special indoor performances free of charge for the handicapped, shut-ins and senior citizens.

The Peripatetic Task Force of Chicago supports touring of plays by children and free theatre for senior citizens centers and hospitals.

The Watts Community Symphony Orchestra in Los Angeles supports a program of free intergenerational music lessons.

Dayton Civic Ballet, Inc., offers a series of noontime performances in the downtown Dayton area for shoppers, workers and older adults.

New Stage, Inc., in Jackson, Miss., provides theatre for low-income elderly citizens by ticket disbursement through the Jackson Department of Allied Services.

PROGRAM ACCESSIBILITY

It is vitally important that older adults who have so often been pushed aside at retirement age and who no longer feel they are contributing members of society not only have access to arts activities, but become actively involvd in the arts. Programs which have encouraged participation by older individuals have found that not only do the older people enjoy and often gain a new self-respect, but the artists and other participants are richer as a result of their participation. Grants have been made to the following organizations which encourage active involvement by older individuals:

COMPAS, in St. Paul, supports arts workshops and arts activities at various neighborhood sites and involves professional artists in community arts programs and artist residencies with older persons.

Community Center fo rthe Creative Arts in Greeley, Colo., encourages fine arts programs within communities and particularly includes senior citizens.

Bronx Community College has expanded project SPEAR (senior's program in education arts and recreation) to include more participation by elderly people, to stimulate workshop participation, to develop access for elderly arts students into the college's facilities, and to introduce progressive art courses which take individual students at their own speed.

Community Film Workshop in New York provides instruction in video technique to entire communities including seniors.

Lively Arts Parade in Boston has workshops for senior citizens held in conjunction with its performance season.

The Madison Civic Repertory Theatre in Wisconsin continued a program by a community-based theatre house in a retirement complex to provide multi-level involvement by seniors.

The Bilingual Foundation of Arts in Van Nuys, Calif., through the Esperanza Theatre, presents Spanish-English plays for intergenerational audiences and offers the audience a followup dialog after the performance with members of the cast and the director.

The Friends of Mime Theatre/London Theatre Workshop Ltd., in Milwaukee, suports a theatre arts program of performances and workshops for the entire community including the elderly.

The Iowa State Arts Council has developed arts programs for the aging directed by professional artists in every discipline emphasizing participation and community interaction.

The Durham Fund for Research and Development of Cultural Arts in St. Louis provides various cultural enrichment programs for older citizens, and institutionalized populations through a core of artists, educators, and researchers.

The Learning Guild, Inc., in Boston, continues their intergenerational arts program, which pairs elementary and secondary school children with senior citizens in workshops in music, photography, theatre, dance, painting, poetry, writing and puppetry.

Karamu House in Cleveland provides senior workshops in choral music, drama, visual arts and crafts.

The Dance Exchange, Washington, D.C., provides an innovative program of classes for older adults in the Washington Metropolitan area.

The Endowment's literature program has supported the following arts programs for senior citizens:

The Frederic Burk Foundation for Education in San Francisco has expanded its writer-in-resident program to include a full program with a group of senior citizens.

The Henry Street Settlement in New York has provided a 10-week residency for various writers. Activities include a weekly workshop for adults interested in fiction, nonfiction, and poetry writing, a weekly workshop specifically oriented to older adults, and a series of three public readings followed by an open discussion period.

The University of Louisville has developed a series of three residencies for writers of different genres to give workshops, consultations, and readings at various sites through the city including senior citizens centers.

The folk arts program has expanded its support of older adults. Although some of the programs funded are not directed specifically toward older Americans, the older adult constituency has benefited directly from the program's activities:

The Jewish Community Centers for South Florida, Inc., sponsored a 10-day Yiddish cultural festival, including elderly Yiddishists and artisans living in the South Beach area. The festival included a dance troupe, lectures, discussions, development of poetry and writing groups and demonstrations of Yiddish folklore and art.

The Alaska State Council on the Arts has invited six mask-makers of Alaska Native cultures to participate in demonstrations of their skills at the native arts festival of the University of Alaska.

The American Indian Historical Society of San Francisco gathered and documented the folk arts history of three major tribes in California.

The Institute for Southern Studies, Inc., in Atlanta, continued field investigation and documentation of folk arts in southeastern Illinois.

Berks Community Television in Reading, Pa., developed a cable television program series which dealt with the creative traditions of the residents of Berks County, Pa.

The Office of Navajo Economic Opportunity in Arizona supported a 2-day tribal elders workshop to teach Navajo children traditional arts, crafts, and music.

Not only is it important to document the folk traditions of a particular local culture, but also it is extremely valuable to document the life and accomplishments of older artists, and make the documentation available to the public in order to provide role-models for older persons. In this regard, the music program at the Endowment has provided funds to aid Hedy West of Stony Brook, N.Y., to record the life and music of Lillian West, who is 89.

Access to the arts for older Americans has been supported increasingly by regional and State arts agencies. The Federal-State partnership program encourages its grantees to make the arts more available to older Americans. Two examples of fiscal year 1978 grants are cited below:

> The Mid-America Arts Alliance received a grant to support the expansion of its initiatives to provide greater opportunities for access to multi-State programs by nonwhite, older and handicapped individuals. This expansion emphasized involving these particular constituencies in program planning, identifying and strengthening new local sponsoring organizations which represented these constituencies, and assisted traditional community sponsors in upgrading their efforts at marketing arts activities for these constituencies.
>
> The Western States Arts Foundation received a grant to design and implement a plan to provide increased access for ethnic groups and minority populations to regional arts activities. The Foundation provides a model for other state and community arts agencies, with a final evaluative report containing recommendations for further implementation of the project.

The special projects program supported some innovative arts and aging projects during fiscal year 1978:

> One of the most exciting special projects grants was awarded to the New School for Social Research to develop a creative arts center for older adults and to pilot a training program and curriculum serving approximately 50 professionals (artists, adult educations, senior center directors). Since training programs are essential to the development of quality arts programs for older adults, the New School's pilot could serve as a model for colleges, universities and communities seeking to develop life-long learning opportunities.
>
> Museums Collaborative, Inc., in New York City, has increased its constituency of community organizations and arts institutions through a culture voucher program. Through this voucher arrangement, community groups of older adults are visiting cultural institutions for the first time.
>
> The Iowa Arts Council documentetd its highly successful statewide arts and aging program on slide cassette and in booklet form and is making both available to the public.
>
> Hospital Audiences, Inc., in New York City, is responsible for bringing artists to nursing homes and hospitals for performances and demonstrations.
>
> Duke University Medical Center in Durham, N.C., has begun a pilot effort to integrate the visual and performing arts into the hospital setting not only for patients, but also for their families, hospital adminstrators and staffs.

The Arts Endowment and the National Council on the Arts will continue its commitment to make the arts more available to older adults and to encourage its applicants and grantees to involve older individuals in their activities.

The Committee on Aging's continued interest in and support of the Endowment's activities relating to older people are greatly appreciated.

ITEM 22. NATIONAL ENDOWMENT FOR THE HUMANITIES

JANUARY 15, 1979.

DEAR SENATOR CHURCH: In response to your request, I am pleased to enclose a report summarizing major activities for the aging supported by the National Endowment for the Humanities in 1978.

I hope that you and your committee will find this report of our activities helpful. I also hope that those who read the report find that it suggests varied ways in which humanities projects can be designed to benefit older Americans and to increase understanding both of their problems and the contributions they can make.

Please let me know if we can be of any further help to your committee.

Sincerely,

JOSEPH D. DUFFEY, *Chairman*.

Enclosure.

505

REPORT ON ACTIVITIES AFFECTING OLDER AMERICANS IN 1978

INTRODUCTION

The Endowment recognizes the important contributions older Americans can and do make to this society; it also recognizes the need of older citizens to have access to information and perspectives that can aid them in making informed decisions as they confront personal and public problems and choices. Therefore NEH encourages increased utilization by the elderly of Endowment-supported products (such as print materials, radio and television programs), and participation of older Americans in a wide variety of NEH-supported activities, including scholarship, the pursuit of additional knowledge through formal and informal educational programs, and discussions of vital public policy questions in communities across the nation.

In carrying out its congressional mandate to encourage the understanding and use of humanistic knowledge in the United States, NEH responds to needs and interests in the humanities, primarily as they are expressed in applications for specific projects. The agency does not normally designate fixed amounts of money for work in any subject area or for particular groups of individuals. Consequently there is no special NEH program for older citizens utilizing funds allocated for that group; nor is there a formal program to support study of the processes and problems associated with aging.

However, through its regular procedure for selection and support, NEH has funded a number of projects specifically designed to increase understanding or attitudes toward aging, and to provide learning experiences in the humanities for the elderly. In addition, regrants of NEH funds through the State-based humanities committees have supported many locally initiated and conducted projects of these types.

All of the activities supported by NEH to increase understanding and use of the humanities *among the general public* reach large numbers of older Americans. The following programs are particularly relevant or useful to older citizens:

Media programs.—The quality radio and television productions supported by the Endowment (e.g., the Adams Chronicle, the American Short Story series) are especially useful to older people, many of whom cannot or prefer not to leave homes. NEH encourages grantees to promote the use of media productions among senior citizens and urges applicants to plan media programs with this group in mind. Specific information on media programs and any adjunct material produced is provided to all organizations working for special groups, including the elderly.

In addition, many institutions of higher education, including community colleges, are offering courses for credit using NEH-supported television programs and accompanying written material. These courses, some of which do not require attendance on campus, are good opportunities for continuing a lifelong education, particularly for those elderly whose mobility may be limited by health or transportation problems.

Humanities radio programming serves a wide audience, including the visually handicapped, who might have limited access to the humanities in other media. For many elderly people confronting problems such as impaired vision and reduced programs, these Endowment-funded programs provide access to information as well as a mechanism for communicating with others.

Courses by Newspaper.—Since 1973, Courses by Newspaper has—with the support of the Endowment—been preparing materials for nontraditional college-level of courses at University Extension, University of California, San Diego. These courses are offered to the general public nationally each September and January through the cooperation of hundreds of participating newspapers and educational institutions. A series of newspaper articles prepared by outstanding scholars serves as the basis of a course offered at local colleges and universities for those readers desirous of earning college credit. More than 450 newspapers and 300 colleges and universities cooperate regularly to bring these courses to citizens of every State, Puerto Rico, Guam, the Virgin Islands, as well as parts of Europe, Canada, New Zealand, and the Far East.

Courses by Newspaper offers several options for those who want to engage in lifelong learning. Use of the courses can vary from reading the articles only, to independent study of additional print material, to enrollment for college credit at hundreds of institutions in all parts of the Nation. Readership for the articles has always included a significant number of older Americans (20–40 percent of the total readership is over 65).

In addition to their function as course materials, the materials developed for Courses by Newspaper can be used to stimulate public discussions in town meeting formats; as the basis for community programs at libraries; and as the outline for thought-provoking discussion by civic groups, churches, community organizations, and service clubs—all organizations with large numbers of elderly members.

The two Courses by Newspaper in 1978 were on popular culture and taxation.

SPECIFIC NEH GRANTS SERVING THE ELDERLY

In 1978, the Endowment awarded aproximately $1,189,000 for projects specifically designed to increase knowledge about aging or to provide special materials or activities for older persons. These projects might be divided into three categories: (1) research on aging and the elderly in our society; (2) programs *for* older Americans; and (3) programs using senior citizens as consultants or resource people. Examples of the programs funded follow:

A. Research on Aging

(1) Aging: New perspectives in introductory courses in the humanities.—This grant was made in suport of a new introductory humanities curriculum at Case Western Reserve University designed to increase student awareness of the positive aspects of aging and to dispel their negative attitudes toward older people. Teaching strategies include seminars, field trips, team teaching, films, and role playing. Faculty for the courses are drawn from the departments of art, literature, classics, history, American studies, and music, and they, as well as their students, are sensitized to the concerns of the aging through the new curriculum.

(2) Humanities planning grant—KAXE.—This award to KAXE, Northern Community Radio in Grand Rapids, Minn., was used to set up meetings between selected scholars and historical societies and KAXE staff to discuss and identify possible program subjects. The station was especially interested in further exploring programming possibilities around humanistic perspectives on the aging process.

(3) WCBB program planning grant.—Like the previous grant, this one was made by the Endowment's media programs. Channel 10—WCBB—in Lewiston, Maine used the award to finance a permanent steering committee to develop humanities program ideas for the station. Like KAXE, WCBB is particularly interested in developing programs on topics related to aging.

(4) Class, age, and sex inequalities: A comparative analysis.—This summer fellowship, awarded to a researcher in sociology at Rutgers University, supported a study on social stratification and various types of social inequality. Class stratification was compared with two other forms of discrimination—age and sex. Based upon the assumption that there is an underlying kinship among all types of social inequality, the three types of stratification were analyzed in terms of their impact upon both the individual and our society as a whole.

(5) Medicine, aging, and human values.—This grant to Michigan State University was used to secure released time for humanities faculty to introduce six new interdisciplinary courses dealing with aspects of medicine and human values. The new courses to be offered include two on aging and human values; one for graduate students in medicine, nursing, social work, public administration, and family ecology; the other for advanced undergraduates in all fields. Another of the courses introduced is on aging in America: now and later.

B. Programs for Older Americans

(1) Senior center humanities program.—This award was made to the National Council on the Aging for a program of group discussions led by trained volunteers and supplemented by community related projects, outside research and reading, and films. The program seeks to offer opportunities for older Americans to become actively involved in community affairs and in independent projects centering around their interests in the humanities. The program will be offered at 400 locations, including senior centers, church clubs, libraries, labor halls, nursing and retirement homes, and it is expected that when the project is completed in June, 1979, 50,000 persons will have participated in it.

(2) Humanities programs for residents of senior citizens housing.—B'nai B'rith has been given support for a survey of the need for and interest in humanities programming by the elderly residing in senior citizens housing, using residents of B'nai B'rith housing as a sample group. A listing of existing humanities programs for the elderly was compiled, and a panel of experts in both humanities and aging met to analyze the results and plan new programs based on the information gathered.

(3) Oklahoma image.—This grant to the Oklahoma Department of Libraries is to improve libraries services and promote quality humanities programs, stressing Oklahoma's multicultural heritage. Senior citizens are among the major audiences for these programs.

(4) A course on contemporary American music for public schools, community centers, and nursing homes.—A student at Brandeis University in Waltham, Mass. was the recipient of this youth grant in the humanities. With the Endowment's financial support, she will prepare a lecture/concert course of study on American contemporary music for young children and senior citizens. The curriculum, which will include an oral history of contemporary composers and their music, will be taught in a university course on the aging and disturbed to agencies, community centers and colleges, and music teachers and public school systems across the country.

(5) Intergenerational humanities program.—The purpose of this grant to the Learning Guild in Boston, Mass., is to establish ongoing intergenerational humanities programs by pairing youth groups with elderly organizations. Young and old will participate in humanities programs—led by professional humanists from the community—integrating values, philosophy, and history and focusing on such topics as "growing up, growing old" and "as it was/our town." About 2,000 persons are expected to participate in the program.

(6) "Northeastern Wisconsin multimedia museum education project.—With this award, the Neville Public Museum in Green Bay, Wis., will develop an outreach program to service the hospitals, homes for the elderly, senior citizens centers, and physical rehabilitation centers in Northwestern Wisconsin. Ten multimedia traveling exhibits on the history of Wisconsin including slide/tape presentations and museum artifacts, will be developed as part of this project.

(7) Volunteers in the public humanities.—A grant from NEH will enable the National Center for Voluntary Action to develop communications and human support networks for volunteer programs in the public humanities from "hard to reach" groups. Programs for minorities, low income individuals, the elderly, and the handicapped will be set up by volunteers recruited from these constituencies. The purpose of the project—which runs through March 1979—is to demonstrate that, if provided with equal resources, these groups can conduct volunteer programs as successfully as these.

C. Programs Using Senior Citizens as Consultants or Resource People

(1) All-Yuman applied workshop in language and culture.—This grant to San Diego State University will support a 4-week workshop for approximately 20 native speakers of Yuman languages who are involved in education. The staff will include not only educators and professional linguists with knowledge of Native American bilingual education and of Yuman languages, but also elderly tribal members with valuable knowledge of their tribal culture and history.

(2) Oral ethnic history presented through popular culture activities.—With the support of this award from the Endowmen'ts office of youth programs, black youth in Decatur, Ill., will collect oral histories from their elders and present this information, using popular culture communications forms, to the community.

(3) Living Atlanta.—The Radio Free Georgia Broadcasting Foundation, with funding from the NEH, will produce, broadcast, and distribute a series of 45 half-hour documentaries on aspects of Atlanta's history between World Wars I and II. The programs will focus on the experiences of blacks and whites in a segregated city and will be based on the recollections of six older citizens. After their initial airing, the radio programs will be distributed to other stations.

(4) Historical slide show of Fort Yukon.—This grant enabled the Kinjii Zhuu Enjit Museum in Yukon, Alaska, to gather information on the history of Fort Yukon, through interviews of older people in the community, photographs, sketches, and materials in the University of Alaska (Fairbanks) library. From

this data a set of slides and a tape were assembled which depicts the people, events, and historical significance of the area.

(5) The architectural history of Bangor, Maine.—A researcher in Bangor, Maine is receiving support from the Endowment to produce a book-length, illustrated monograph documenting the social and stylistic development of the distinguished architectural landmarks of Bangor, Maine. The systematic study will use the recollections of elderly residents, old prints, photographs, journals, and court records as sources. The result, expected in 1980, will be a useful tool in the preservation and planning process of the city.

(6) AFL–CIO labor movement oral history project.—With the help of this award, researchers at the George Meany Centre for Labor Studies will conduct an oral history project of the American labor movement, interviewing 50 or more leaders and participants who played key roles in it. Much of the information about the movement has not been recorded in print, and many of the movement's leaders are aging, which lends this project special importance. Materials collected will be made available to historians and interested individuals and groups of many kinds.

STATE PROGRAMS

The State programs division of the Endowment makes grants in the 50 States and in Puerto Rico to State humanities committees. These committees, in turn, respond to competitive applications from institutions and organizations within the State for humanities projects of broad benefit to the citizens of the State. The majority of the projects funded across the country focus on issues of public policy or of contemporary concern to the society. Therefore, many projects deal with the topics of biomedical ethics, death and dying, the status of the family within the society, and with other issues of particular concern to the elderly. Below, we have tried to enumerate projects which are specifically directed towards the elderly or focusing directly on the problems of the elderly rather than on the galaxy of related issues of health care, family, etc., enumerated above.

Like the Endowment as a whole, the division of State programs has no computerized records of its grant-making activity and, as a result, no way of knowing exactly how many programs State committees sponsor each year for the elderly.

Some sense of distribution can be gained, however, by a sampling of individual State committee lists of projects funded:

—In Colorado, between September 1, 1976, and August 31, 1977, 3 out of 86 grants were made for projects oriented specifically toward the elderly, while the committee listed 7 projects overall (including the above 3) that dealt with issues related to the elderly either directly or indirectly. This compares with committee listings of 3 projects dealing with rural problems; 3 with the family; 7 with women; 1 on property taxes; 6 on minority affairs; 5 on historic preservation; and one on foreign affairs (plus other grants dealing with some ten additional topics).Examples of projects funded by the Colorado committee are given later in this report.

—In Florida, a State with obvious interest in the elderly, committee records for the period August, 1976 to August, 1977 (12 months) list 42 projects funded overall, with 2 of these specifically designed for the elderly. Indirectly, however, at least three-fourths of the committee's programs dealt with issues of interest to the elderly, since programs on such topics as legislative representation and health care cannot avoid the subject in a State such as Florida.

—In Ohio, during the last 9 months of 1973, the committee funded 66 projects, only one of which dealt directly with the elderly. This State committee gave much greater emphasis to other issues, such as the problems of cities, the role of minorities, foreign affairs, the role of women, the energy crisis, and health care.

—In Virginia, in the period October 1977 to June 1978, the committee funded 75 projects, two of which were oriented specifically toward the elderly. These two projects are described in this memorandum. The spread of other issues and topics addressed by the Virginia committee resembled that described above for Colorado.

Examples of State-based Projects Directly Affecting Older Citizens

Of the many State-based regrant projects undertaken in 1978, the following few suggest the nature of the program and, it is hoped, will prove suggestive of content and concepts that can be duplicated elsewhere.

Although the variety of these projects can only be suggested here, they generally include one or more of the following features: exploring the values and assumptions implicit in our behavior toward the elderly at present; exploring attitudes toward aging in other cultures or in other times in our history; considering future alternatives to our present behavior and attitudes; exploring major public issues with audiences limited to the elderly; and programs on the topics of death and dying.

Florida.—The Florida committee sponsored two projects specifically for the elderly:

(1) The committee awarded $12,000 to the Hillsborough County Office on Aging for a conference entitled "Retirement: Its Problems and Prospects" which drew an audience of 400 participants. While most participants were women, the conference attracted a wide range of retired people—rich, poor, white, black, Jewish, Hispanic, middle class, working class. The conference featured speakers, small group discussions, poetry readings, singing, and quotations from essays written by participants. Eight scholars in the humanities assisted a core group of retirees in planning the program.

(2) The committee awarded $6,500 to the Pinellas County Interfaith Council on Aging for "The Future of Aging in Florida," a series of major addresses followed by small group workshops led by scholars in the humanities that involved over 2,000 participants. Discussion focused particularly on the problems that technology is likely to create for the elderly.

Alaska.—The Alaska State humanities committee awarded a grant of $22,000 to the Northwest Alaska Native Association for "Inupiaq Elders Conference," in which 30 of the most respected old people were brought together in Kotzebue to discuss the heritage of the Inupiaq Eskimos and the role that the elder plays in transmitting Eskimo culture. The project was planned by the Eskimo people in and around Kotzebue, who selected the issues for discussion and undertook the extensive word-of-mouth publicity that resulted in attendance by 75 participants. The conference spanned 10 days, with intensive discussions from morning into the night on such subjects as the Elder's role as community leader; how Elders have reacted to western religions; difficulties of teaching love of nature and animals in an industrializing, urbanizing society; future prospects for preservation of Eskimo identity; and the importance of ceremonies performed by Elders. Proceedings of this conference were videotaped for future use in other community discussion programs.

Virginia.—The Virginia State committee made two major grants for programs related to the elderly:

(1) The committee awarded $6,000 to an ad-hoc group of citizens in the city of Hampton for a 3-day conference on the possible use of Asian attitudes toward the elderly as guiding concepts for public policy toward the elderly in the United States. Attendance averaged 150 each day, including representatives from local colleges, churches, and the U.S. State Department, as well as a broad cross section of Hampton citizens. Contrasts were drawn between eastern and western notions of health care, social importance of the elderly, and conceptions of the elderly as embodied in religion and literature. After the conference, some 40 participants were sufficiently enthused to begin preparation for a future gathering on African attitudes toward the elderly, which is expected to be funded in the near future.

(2) The committee awarded $2,950 to the Virginia Center on Aging and the Virginia Commonwealth University for a series of three weekly forums focusing on the dominant values that have shaped American attitudes toward the aging. Attendance averaged 150 per forum. At each session, well-known scholars gave major addresses that were followed by small discussion groups led by humanists. The programs were open to the public, and the proceedings will be transcribed and published for distribution throughout Virginia.

Ohio.—The Ohio humanities committee awarded a grant of $11,495 for "The More Things Change . . .," a series of two 10-week discussion programs held at three retirement homes in the Cincinnati area. Residents and visiting humanities scholars explored problems and issues related to new forms of government, new legislation, and new discoveries in science and medicine that may bring about changes in the role of the elderly in America. The project was jointly sponsored by the Department of English at the University of Cincinnati.

Arizona.—The Arizona committee awarded $1,140 for two local discussion programs based on materials for the elderly originally prepared with a major grant from NEH to the National Council on Aging. At two senior centers, in Flagstaff and Williams, 1½-hour discussions were held each week for seven weeks based on such texts as the family album, the family in literature and history, and Americans and the land—publications prepared by the National Council on Aging to deal with subjects judged to be of special interest to the elderly. The same material was also made available on cassettes for the participants who could no longer read and in written form in Spanish. Each discussion began over lunch at the retirement center and then was continued informally for as long as participants desired. Programs received favorable publicity in Arizona media, and the Arizona committee anticipates funding more such programs in response to popular demand.

Colorado.—The Colorado committee funded three programs related to the elderly:

(1) The committee awarded $8,560 to a consortium of five northwestern Colorado organizations for development of a multimedia show on the problems of growing old in rural Colorado. The program was based on extensive interviews with older residents of the area and made extensive use of old photographs. The multimedia show was made available for distribution throughout Colorado and has been used in many communities to stimulate discussions of the humanistic issues it raises.

(2) The committee awarded $7,653 for "Age Segregation: Three Score and Then," a 30-minute television documentary aired on Channel 9-KBTV. A second grant is planned to permit viewing of the film and discussion of the issues it raises at 12 university communities throughout the state. Vigorous publicity will be designed to ensure that discussions are attended by the general public as well as by residents of local senior citizens' homes.

(3) The committee awarded $1,000 to a group of Northern Colorado organization to produce a 30-minute, 16 mm film focusing on four senior citizens from different backgrounds. The film will be used by institutional personnel and is designed to sensitize them to humanistic aspects of their work.

ITEM 23. NATIONAL SCIENCE FOUNDATION

MARCH 19, 1979.

DEAR SENATOR CHILES: This is in response to your recent request for a summary description of National Science Foundation (NSF) activities related to aging. The Foundation provides limited support for aging-related research.

The major funding agency for support of research dealing with aging of animal systems and health-related problems is the Institute of Aging of the National Institutes of Health. Within the Foundation, the Directorate for Applied Science and Research Applications has supported several applied social science projects on policy issues related to the status of the elderly. The Directorate for Science Education has supported several needs-assessment projects, particularly in relation to social and health services program planning, as well as education and information exchange projects.

The Directorate for Biological, Behavioral, and Social Sciences provides support for basic research projects related to aging in humans as well as plants. This research ranges from plant senescence, to senescence of nervous systems, to developmental behavioral problems associated with aging humans. The basic research on plant senescence has potential agricultural implications. For example, delays in plant aging could result in increased plant productivity. Additionally, understanding the processes underlying aging of plants is necessary for development of general biological theories and concepts about the aging process.

Enclosed are copies of the project summaries and program award recommendations for NSF-supported projects related to aging.

If I can be of further assistance, please let me know.

Sincerely yours,

PATRICIA E. NICELY,
Head Congressional Liaison.

Enclosures.

511

NATIONAL SCIENCE FOUNDATION

PROJECT SUMMARY

NSF AWARD NO.

NAME OF INSTITUTION (NSF DIRECTORY NAME)
Koba Associates, Inc.

ADDRESS OF INSTITUTION (INCLUDE BRANCH/CAMPUS & COMPONENT)
Washington, D.C. 20009

PRINCIPAL INVESTIGATOR
Peabody, Gerald

DIVISION (OFFICE) AND DIRECTORATE Advanced Productivity Research and Technology

SECTION
Public Policy

PROPOSAL NUMBER
APR-7684310

FISCAL YEAR
1977

PROGRAM
Distribution and Equity

TITLE OF PROJECT
Condition Forecast: Economic Welfare Among Retirement Aged Blacks in the Year 2000

SUMMARY OF PROPOSED WORK (LIMIT TO 22 PICA OR 18 ELITE TYPEWRITTEN LINES)

A national discussion is growing about the economic condition of the aged and the resources that society is willing to commit to their support. Very little research has been focused on the effects of advancing age on the disadvantaged members of the population, especially the racial minorities.

The purpose of this study is to assess the relative economic position of a cohort of blacks reaching retirement age in the year 2000. Attention will be paid to effects of imcome from earnings, social security, Supplemental Security Income (SSI) and private pension on the economic well-being of blacks vs. whites. This will provide an information basis to assess the extent to which aged blacks in the future will receive an adequate income. This assessment will provide a basis for evaluating the impact of public and private policy options which could affect the future welfare of black aged.

The Urban Institute Micro-analytical Model (UIMM) provides much of the basic data for the study. Private pension data and an update of current labor market characteristics will be added to the data file. Additional data will be obtained from the National Survey of Labor Force Experience (Parnes Study) and the 1970 census.

PROGRAM APPROVAL
George E. Brosseau

DATE
3/31/77

INSTRUCTIONS FOR USE

1. Program Office will complete all items appearing on the first copy, place Proposal Folder copy in the folder, retain Program Suspense copy, and place other copies inside the folder envelope with carbons intact.
2. Division of Grants and Contracts will post award number, amount granted and inclusive project dates on copies 3 through 7 and distribute these copies.

NATIONAL SCIENCE FOUNDATION

PROGRAM AWARD RECOMMENDATION	PROPOSAL NUMBER APR-7683410

The APRT program in aging research is concerned with distribution and equity issues as they impact the quality of life of the elderly. We have identified the problem of work and retirement as one of the most important emerging problem areas, reachi its maximum impact over the next 25 years. The equity aspects of support for minority elderly are especially poorly understood. This project would make a major step forward in filling this void.

The use of micro simulation is probably the only way that meaningful studies of future economic well-being can be made. It is a good tool for evaluating the consequences of alternative policy options. The data sources are adequate, the analytical techniques are simple and straight forward.

The Principal Investigator is very experienced with the micro simulation model, being one of those who worked on its development. He is experienced and competent in the necessary areas of analysis and data management.

The proposal received reviewer support from technical and user reviewers. The problem is important and relevant to NSF programming and user needs. It is recommended for funding at $351,000 for 24 months.

The first 12-month award would be $175,500 starting February 1, 1977. Given satisfactory performance, a second 12-month period at $175,500 would be awarded. These awards would complete the project objectives.

PROGRAM OFFICER	DATE 3/31/77

NSF FORM 8 MAY 76

WHITE COPY (OGC)
YELLOW COPY (PROGRAM)

NATIONAL SCIENCE FOUNDATION

PROJECT SUMMARY

NSF GRANT NO.

NAME OF INSTITUTION (NSF DIRECTORY NAME)
Florence Heller Graduate School
Brandeis University

ADDRESS OF INSTITUTION (INCLUDE BRANCH/CAMPUS & COMPONENT)
Waltham, Massachusetts

PRINCIPAL INVESTIGATOR
James H. Schulz

SOCIAL SECURITY NO.

DIVISION (OFFICE) AND DIRECTORATE
Advanced Productivity Research & Technology

SECTION
Public Policy and the Disadvantaged

PROPOSAL NUMBER
APR-7523383

PROGRAM
Public Policy and Human Resources

TITLE OF PROJECT
Economic Impact of Private Pensions

SUMMARY OF PROPOSED WORK (LIMIT TO 22 PICA OR 18 ELITE TYPEWRITTEN LINES)

Pensions have played a major role in the improvement of the aged's economic situation. The economic impact of private pensions is being virtually ignored in current research. Pension policy is now at a crossroads in determining the mix of private and public pensions. It is necessary to develop research tools to evaluate the many arguments currently being made with regard to income maintenance policy and the role of pensions.

This project will develop a microsimulation private pension model to investigate the future impact of private pensions on the economic status of the elderly. This model will be used to investigate: (a) the distribution and magnitude of future private pension income, (b) the impact of private pensions on the economic status of the aged, and (c) the implication of vesting standards specified in the pension reform act (1974) for a & b.

The simulation model will permit microanalysis of the earning replacement potential of private pensions as they are currently developing. It will also permit analysis of alternatives to or changes in current private pensions mechanisms.

INSTRUCTIONS FOR USE

1. Program Office will complete all items appearing on the first copy; place Proposal Folder copy in the folder; retain Program Suspense copy, and place other copies inside the folder envelope with carbons intact.
2. Grants and Contracts Office will post grant number, amount granted and inclusive project dates on the S.I.E. copy and make distribution of remaining copies.

NSF Form 4, Jan. 1970

1. PROPOSAL FOLDER

NATIONAL SCIENCE FOUNDATION

PROGRAM AWARD RECOMMENDATION	PROPOSAL NUMBER APR-7523383

The economics of aging is an inadequately investigated field and there are relatively few economists working on it. Within that field, the private pension is clearly the most neglected area, and yet in terms of development of pension policy, it is an extremely important one. This project would move forward to fill this gap by the development of analytical tools for the better understanding of the impact of various pension options especially as they relate social security with the private pension system.

Review support for the proposal is substantial. Dr. Schulz is a recognized authority in this area and has done virtually all the definitive work. Review comments include favorable comment on Dr. Schulz's capability and on the appropriateness and feasibility of the proposed microsimulation techniques for carrying out the project.

A major concern in aging is the question of adequacy of income and income maintenance. The NSF program on public policy and aging is particularly concerned with future projections on the role of the elderly in society. Income adequacy is an important component in maintaining a meaningful role for the elderly. Therefore this project is directly relevant to the NSF program and is a high priority in program development. For these reasons and - the demonstrated scientific merit of the project, it is recommended for funding in the amount of $205,800.

PROGRAM OFFICER	DATE
	March 24, 1976

NSF FORM 9 APR. 72

WHITE COPY (GCO)
YELLOW COPY (PROGRAM)

NATIONAL SCIENCE FOUNDATION

PROJECT
SUMMARY

NSF GRANT NO.

NAME OF INSTITUTION (NSF DIRECTORY NAME) The RAND Corporation	ADDRESS OF INSTITUTION (INCLUDE BRANCH/CAMPUS & COMPONENT) 1700 Main Street Santa Monica, California 90406
PRINCIPAL INVESTIGATOR / SOCIAL SECURITY NO. Tora K. Bikson	DIVISION (OFFICE) AND DIRECTORATE Advanced Productivity Research & Technology SECTION Consumer Policy
PROPOSAL NUMBER APR-7520134	PROGRAM Public Policy and Human Resources

TITLE OF PROJECT

Decision Making Processes Among the Elderly Consumers

SUMMARY OF PROPOSED WORK (LIMIT TO 22 PICA OR 18 ELITE TYPEWRITTEN LINES)

This project will attempt to determine how older consumers as compared to younger consumers, make product choices.

Using piloting and sampling procedures, elicitation techniques leading to rating scales, interviews and multidimensional scaling, the RAND Corporation will perform the project in four stages: (1) experimental pilot project to explore how products are perceived, to pretest procedures, and to develop and implement a sample design; (2) obtaining product ratings from the participants; (3) examination of the manner in which older and younger consumers weight product attributes and arrive at "optimum choices," and (3) establishing aspects of the product decision situation which can be modified to improve product choice by older people.

$187,800/12 months, beginning 6/1/76

INSTRUCTIONS FOR USE

1. Program Office will complete all items appearing on the first copy, place Proposal Folder copy in the folder, retain Program Suspense copy, and place other copies inside the folder envelope with carbons intact.
2. Grants and Contracts Office will post grant number, amount granted and inclusive project dates on the S.I.E. copy and make distribution of remaining copies.

NSF Form 4, Jan. 1970

1. PROPOSAL FOLDER

NATIONAL SCIENCE FOUNDATION

PROGRAM AWARD RECOMMENDATION	PROPOSAL NUMBER APR-7520134

This project addresses an area that seems to have been neglected by existing research. That is, the investigation of how a significantly expanding segment of the population (persons 65 and over) differs from consumers (30-50 years old) insofar as product choices are concerned. The policy issues involved, therefore, are not only those of protecting the aging population, but of predicting and preparing for the increasing impact of that population on consumer markets.

The proposal was reviewed by gerontologists, consumer behavior experts, and Federal officials. The review revealed both merit and methodological flaws in the proposed project. An amended proposal revised the project's methods in response to the suggestion offered and the proposal was rereviewed. A significant upgrading of the proposal resulted, bringing it into the range suitable for funding.

The project bridges two programatic interests in APRT. It is related to APRT concerns about distribution and equity. It is relevent to our consumer policy program concern about consumer information processing and decisionmaking and the aging programs concern with the welfare of the elderly in our society.

The project meets NSF/RANN requirements on specific merit and relevance to programming and is recommended for funding at $187,800.

PROGRAM OFFICER	DATE March 11, 1976

NSF FORM 9 APR. 72

WHITE COPY (GCO)
YELLOW COPY (PROGRAM)

NATIONAL SCIENCE FOUNDATION

PROJECT SUMMARY

NSF AWARD NO.

NAME OF INSTITUTION (NSF DIRECTORY NAME)
Portland State University

ADDRESS OF INSTITUTION (INCLUDE BRANCH/CAMPUS & COMPONENT)
P. O. Box 751
Portland, Oregon 97207

PRINCIPAL INVESTIGATOR
John E. O'Brien

DIVISION (OFFICE) AND DIRECTORATE Advanced Productivity Research and Technology

SECTION
Public Policy

PROPOSAL NUMBER
APR-7709913

FISCAL YEAR
1977

PROGRAM
Distribution and Equity

TITLE OF PROJECT
Identification of a Spectrum of Community Support Options for the Elderly

SUMMARY OF PROPOSED WORK (LIMIT TO [illegible] PICA OR [illegible] ELITE TYPEWRITTEN LINES)

The shortcomings of sending the elderly to a home has long been recognized. Today, as a result of the increase in the number of elderly, the scope of the problem has changed raising questions of aggregate demand and the capacity of society to respond with feasible alternatives. This project has assessed the full range of problems and prospects of alternative institutional support arrangements for impaired elderly individuals. It includes an assessment of the possibility, feasibility and desirability of each alternative identified. The study substantially broadens the range of intellectual and practical consideration available regarding critical policy choices about such alternatives.

The assessment has been carried out by Portland State University staff members supplementing their efforts with a set of conferences and written contributions from national experts in order to analyze in detail the feasibility and desirability of each alternative mode that is identified. The alternatives have been delineated and then examined with a general emphasis on resource allocation. The final consideration was the cost and benefits to society and the potential impact of each alternative on the quality of life of the individuals affected.

This renewal (grant # APR-7500190) is to provide for the wide dissemination of the findings of the assessment. These include the definition of social objectives, a model of the human support system; and the analysis of 48 practical program innovations.

PROGRAM APPROVAL
George E. Brosseau

DATE
5/25/77

INSTRUCTIONS FOR USE

1. Program Office will complete all items appearing on the first copy, place Proposal Folder copy in the folder, retain Program Suspense copy, and place other copies inside the folder envelope with carbons intact.
2. Division of Grants and Contracts will post award number, amount granted and inclusive project dates on copies 3 through 7 and distribute these copies.

NSF Form 6, 10-76 Existing stocks will be used.

1. PROPOSAL FOLDER

NATIONAL SCIENCE FOUNDATION

PROGRAM AWARD RECOMMENDATION	PROPOSAL NUMBER APR77-09918

The Division of Advanced Productivity Research and Technology has supported social policy research concerned with the needs of the elderly and on ways to increase productivity in providing services to them. This project renewal is to expand the dissemination activities of one of these projects.

The project is concerned with identifying innovative means of extending the period of independent maintenance of the elderly. The major scientific contribution is in devising a method of generating and pre-testing service innovations.

The principal investigator combines competence in sociology with extensive experience in service delivery. He is very well qualified to direct this project.

The renewal is recommended for funding at $23,700 for 8 months.

PROGRAM OFFICER George E. Brosseau	DATE May 12, 1977

NSF FORM 7 APR. 72

WHITE COPY (GCO)
YELLOW COPY (PROGRAM)

NATIONAL SCIENCE FOUNDATION

PROJECT SUMMARY

NSF GRANT NO.

NAME OF INSTITUTION (NSF DIRECTORY NAME)
Duke University

ADDRESS OF INSTITUTION (INCLUDE BRANCH/CAMPUS & COMPONENT)
School of Medicine
Durham, North Carolina

PRINCIPAL INVESTIGATOR
George L. Maddox

SOCIAL SECURITY NO.

DIVISION (OFFICE) AND DIRECTORATE
Advanced Productivity Research & Technology

SECTION
Public Policy and the Disadvantaged

PROPOSAL NUMBER
APR-7611164

PROGRAM
Public Policy

TITLE OF PROJECT
Age Structure and Economic Change

SUMMARY OF PROPOSED WORK (LIMIT TO [illegible] PICA OR [illegible] ELITE TYPEWRITTEN LINES)

This project will examine the interrelationship between the demographic factors resulting from various low fertility patterns and the economic status of the elderly combined with the ability of the working population to provide the aged with adequate income maintenance. This project will examine (1) the trade-off between lower dependency costs for decreasing number of younger dependents and the increasing cost of supporting the growing number of older dependents, (2) the ability of individuals to accumulate assets to support themselves in late life, (3) the fluctuation of retirement income from various sources over late life, (4) potential shifts in the age-earning profile and the resulting impact on income distribution, and (5) trends in the patterns of labor force participation rates and their implications for the capacity of the non-aged to support the aged.

Investigators from Duke, North Carolina State and University of North Carolina will carry out the project with project responsibility located at Duke's Center for the Study of Aging and Human Development. The reserrch will be based upon the refinement and extension of an econometric-model developed in a predecessor project. Bureau of Census and Department of Labor data will be used for population and labor force projections; Social Security Data for retirement trends; and HEW and DOL data on school attendance trends. The final report will project alternative levels of economic status for the aged given different levels of government support and fertility rates.

$8 ,500/18 months, beginning 8/15/76

INSTRUCTIONS FOR USE

1. Program Office will complete all items appearing on the first copy, place Proposal Folder copy in the folder; retain Program Suspense copy, and place other copies inside the folder envelope with carbons intact.
2. Grants and Contracts Office will post grant number, amount granted and inclusive project dates on the S I E copy and make distribution of remaining copies.

NSF Form 4, Jan. 1970

1. PROPOSAL FOLDER

NATIONAL SCIENCE FOUNDATION

PROGRAM AWARD RECOMMENDATION

PROPOSAL NUMBER
APR-7611164

A previous report from the Center of Aging at Duke University, under award number APR-7302885 A02, analyzed the ability of the working population to support a dependent elderly population under conditions of zero population growth. This report highlighted the need to know more about the intergenerational transfer of funds if reasonable judgements were to be made. The predecessor report has been reviewed now and the reviewers indicate that it will be widely useful.

The work proposed will increase the number of factors explored -- factors that the reviewers agreed are of great interest to policy makers. It is the view of several of the reviewers that the researchers are competent and this research design is sound.

Furthermore, both the methodology to be used and the research team are substantially the same as in the predecessor project, therefore there is reason to believe that the proposed work will be similarly successful. The project is recommended for funding at the requested level of $67,400.

PROGRAM OFFICER
George E. Brosseau, Jr.

DATE

NSF FORM 9 APR. 72

WHITE COPY (GCO)
YELLOW COPY (PROGRAM)

NATIONAL SCIENCE FOUNDATION

PROJECT SUMMARY

NSF GRANT NO.

NAME OF INSTITUTION (NSF DIRECTORY NAME) Duke University	ADDRESS OF INSTITUTION (INCLUDE BRANCH/CAMPUS & COMPONENT) The Duke University Center for the Study of Aging and Human Development Durham, North Carolina 27710
PRINCIPAL INVESTIGATOR George L. Maddox — SOCIAL SECURITY NO. 425-28-9286	DIVISION (OFFICE) AND DIRECTORATE ERPA/RA SECTION
PROPOSAL NUMBER P310282	PROGRAM Human Needs

TITLE OF PROJECT

"Economics of a Stationary Population: Implications for the Elderly"

SUMMARY OF PROPOSED WORK (LIMIT TO 22 PICA OR 26 ELITE TYPEWRITTEN LINES)

The most pressing problem confronting today's elderly is their economic status. To a large degree, the welfare of the aged is conditioned by the financial resources available to them during the retirement period. An overview of the prospective economic position of the elderly is thus fundamental to any analysis of future age related issues.

This investigation will inquire into the changes in age structure of the population and how they pose questions of special significance, such as the effects of a stationary population on the total output of the society and hence on the capacity to support non-working older people. This investigation will include an analysis of the alternative dependency ratios and support patterns deriving from a stable population; the implications of the population's changing age structure for productivity and levels of living; and the substitutes and complements to work in old age. Questions of appropriate retirement policy will be recast in the context of the new population age structure as will the issues of the aged's income and the manner in which it is to reflect changing price levels and growth rates.

$67,100/12 months, beginning 11/1/73
Cumulative Award - $68,200

INSTRUCTIONS FOR USE

1. Program Office will complete all items appearing on the first copy; place Proposal Folder copy in the folder; retain Program Suspense copy; and place other copies inside the folder envelope with carbons intact.

2. Grants and Contracts Office will post grant number, amount granted and inclusive proj[illegible] dates on the S.I.E. copy and make distribution of remaining copies.

NSF Form 4, Jan. 1970

1. PROPOSAL FOLDER

NATIONAL SCIENCE FOUNDATION

Form Approved
OMB No. [illegible]

☐ Public Service Science Residency
☒ Public Service Science Internship

PROPOSED ACTIVITIES PROGRA

Name ASANOVIC (last) Susan (first) ______ (middle) Date May 9, 1977

Social security number 119-34-0874

Proposed host institution Home Care Program, Norwalk, Connecticut

Type or print clearly a non-technical abstract (approximately 200 words) of your proposed activities program which can be used b the National Science Foundation to inform the public if you receive an award.

I propose to work as a consulting nutritionist with the Home Care Progra Systems for Independent Living at the Norwalk, Connecticut Department of Health. Public funds are used to keep the aging out of institutions whe at all possible. My activities would center around helping our senior citizens to better understand public policy regarding nutrition's impact on good health and how to obtain the best possible food with limited economic and physical means. This includes teaching the clients of the Program as well as their families to choose and prepare their food wisel with special attention to food stamp cases. Most of the clients are ver poor. I would assess the impact of Government policy (i.e. F.D.A.) on th availability and value of dietetic foods and supplements for the aging. These goals would be reached through personal interviews with the client and evaluation of each case with the Home Care Program Coordinator, special diet counseling, and talks to senior citizen groups. Finally, I would determine whether public policy for keeping the aging, particular those with medical-dietary problems, out of institutions is effective and possible when the bases of sound nutrition are implemented. I would determine if individualized nutritional counseling for the elderly has significant results, enough to permit many to continue to live at home and carry out meaningful, dignified lives.

Describe in detail, in not more than three (3) typed double spaced pages, your proposed activities program, limiting your descripti to the activities you expect to undertake while on tenure. Do not propose alternative programs. *Be sure your name is on each shee* Attach your program description to this cover sheet and submit along with 5 copies of the entire package.

You are advised to consult the Application Review Criteria (Appendix A of the Program Announcement) in designing your activiti program, and to comment specifically on the following points:

- What you propose to do. Describe your objectives and work plan, explaining how the program will contribute to helping the pu understand science, engineering and technology and their impact on public policies. Describe how it will contribute to the devel ment of facts, issues, and arguments relevant to public policy issues having significant scientific and technical aspects. In partic describe how it will provide an independent perspective which will raise the level of public debate about these issues.
- Where, when, and with whom you plan to conduct your activities program. Comment on the relationship of your activities to t programs and objectives of the host institution. If you plan on other than a continuous tenure, or a tenure of less than 12 mont explain.

Form Approved
OMB No. 99 R0304

NATIONAL SCIENCE FOUNDATION

PROPOSED ACTIVITIES PROGRAM FOR ☒ Public Service Science Residency ☐ Public Service Science Internship

NAME OF APPLICANT Susan Clemont Brutto	SOCIAL SECURITY NO 237-82-7181	DATE 3-6-78

PROPOSED HOST ORGANIZATION
Central Kentucky Community Action Council, Inc.

Type or print clearly, in the box below, a non technical abstract of your proposed activities program which can be used by the National Science Foundation to inform the public if you receive an award

The researcher will use anthropological methods, which include participation, observation and informal interviewing, to gather health-related data in a rural Kentucky community. Based both on the results of this research and on gerontological and geriatric reference material, the researcher will then develop informal educational programs to disseminate relevant medical information to the elderly in an eight-county area of central Kentucky. The elderly citizens of a rural central Kentucky county constitute the research population. Much of this population can also be characterized as poor, belonging to a minority group, and having little formal education. Available statistics indicate that the county chosen for the focused study is representative of an eight-county area development district, thereby making the health education programs generated by the research in this one county relevant to the needs of the elderly citizens in all eight counties. Already existing local radio stations, local newspapers, Title VII of the Older Americans Act nutrition sites, and Senior Citizen Clubs provide the primary channels for disseminating relevant medical information. The initial focused research both prepares the researcher to translate relevant scientific information into programs appropriate to the target group and provides data to local community development organizations interested in planning health-related services for the elderly.

Describe in detail, in not more than four (4) typed double-spaced pages, your proposed activities program, limiting your description to the activities you expect to undertake while on tenure. Do not propose alternative programs. *Be* ***sure your name is on each sheet.*** **Attach your program description to this cover sheet, submit the original and one copy with your application.**

You are advised to consult the Application Review Criteria (Appendix A of the Program Announcement) in designing your activities program, and to comment specifically on the following points

- What you propose to do. Describe your objectives, explaining how your program will contribute to the development and dissemination of scientific facts, issues, and arguments about policy issues in which science and technology play an important part, and will encourage citizens and citizen groups to reach informed decisions and participate effectively in the public policymaking process. Describe your activities plan and methods, and indicate how you expect to assess their success. Describe how your specific knowledge and skills in science and technology will be applied to the particular problems you address.
- Where, when, and with whom you plan to conduct your activities program. Indicate the specific audience to which your program is directed, specifying how you intend to reach this audience. Explain how your program meets the needs of citizens and citizen groups normally lacking access to scientific information. Comment on the appropriateness of the host organization for your program, and on the relationship between your program and new or ongoing activities by the host. Indicate if you have worked with the host organization previously.
- Internship applicants. Indicate the scientific supervision that will be available to you during your tenure. Name specific individuals who have agreed to provide scientific guidance for your program (one of whom should submit a Reference Report for you).

NATIONAL SCIENCE FOUNDATION

Form Approved
OMB No. 99-R0304

PROPOSED ACTIVITIES PROGRAM FOR ☒ Public Service Science Residency ☐ Public Service Science Internship

NAME OF APPLICANT JOE WILLIE CONNER	SOCIAL SECURITY NO. 550-80-9529	DATE 3-7-78

PROPOSED HOST ORGANIZATION
University of Southern California Community Service Center

Type or print clearly, in the box below, a non-technical abstract of your proposed activities program which can be used by the National Science Foundation to inform the public if you receive an award.

THIS RESIDENCY'S INTENT IS TO PRODUCE A SCIENCE AND TECNOLOGY (S/T) SYMPOSIUM FOR THE BLACK COMMUNITY OF METROPOLITAN LOS ANGELES. PRESENTATIONS WILL BE BY BLACK SCIENTISTS AND SHALL CONSIST OF LECTURES, FILMS, PANEL DISCUSSIONS, WORKSHOPS, AND TOURS. THE UNIVERSITY OF SOUTHERN CALIFORNIA COMMUNITY SERVICE CENTER WILL SPONSOR THE SYMPOSIUM. A 12 MEMBER ADVISORY COUNCIL, COMPOSED OF SCIENTISTS AND NON-SCIENTISTS, IS PROPOSED TO SUPERVISE ALL ASPECTS OF THE PLANNING AND ORGANIZATION: TO FACILITATE COMMUNITY PARTICIPATION AND TO MINIMIZE SCIENTIFIC JARGON, WHILE STRESSING CONCEPT CLEARITY. THE FOLLOWING TENTATIVE GOALS ARE SUGGESTED BY THE COMMUNITY SERVICE CENTER: 1. TO ENCOURAGE BLACK PEOPLE TO CONSIDER S/T CAREER OPTIONS, THEREBY INCREASING MINORITY INPUT IN PUBLIC POLICY DECISIONS; 2. TO STRENGTHEN COMMUNITY TIES AMONG BLACK SCIENTISTS AND NON-SCIENTISTS; 3. TO DEVELOP SEVERAL MANAEABLE DEFINITIONS OF S/T AND PUBLIC POLICY, AND SUGGEST METHODS TO ASSESS TRENDS; 4. TO DEVELOP A SHORT FILM DESCRIBING THE SYMPOSIUM.

I SHALL WORK WITH THE ADVISORY COUNCIL TO OBTAIN FUNDS, SCIENTIFIC PERSONNEL AND SUPPORT MATERIALS/SERVICES. BLACK SCIENTISTS FROM ACADEMIA, GOVERNMENTAL AGENCIES, AND INDUSTRY WILL DISCUSS THEIR VIEWS ON S/T, EMPHASIZING FOOD, CAREERS, HEALTH, AND SHELTER.

Describe in detail, in not more than four (4) typed double-spaced pages, your proposed activities program, limiting your description to the activities you expect to undertake while on tenure. Do not propose alternative programs. *Be sure your name is on each sheet.* Attach your program description to this cover sheet; submit the original and one copy with your application.

You are advised to consult the Application Review Criteria (Appendix A of the Program Announcement) in designing your activities program, and to comment specifically on the following points:

- What you propose to do. Describe your objectives, explaining how your program will contribute to the development and dissemination of scientific facts, issues, and arguments about policy issues in which science and technology play an important part, and will encourage citizens and citizen groups to reach informed decisions and participate effectively in the public policymaking process. Describe your activities plan and methods, and indicate how you expect to assess their success. Describe how your specific knowledge and skills in science and technology will be applied to the particular problems you address.
- Where, when, and with whom you plan to conduct your activities program. Indicate the specific audience to which your program is directed, specifying how you intend to reach this audience. Explain how your program meets the needs of citizens and citizen groups normally lacking access to scientific information. Comment on the appropriateness of the host organization for your program, and on the relationship between your program and new or ongoing activities by the host. Indicate if you have worked with the host organization previously.
- Internship applicants: Indicate the scientific supervision that will be available to you during your tenure. Name specific individuals who have agreed to provide scientific guidance for your program (one of whom should submit a Reference Report for you).

NATIONAL SCIENCE FOUNDATION

PROJECT SUMMARY

NSF AWARD NO.

NAME OF INSTITUTION (NSF DIRECTORY NAME)

University of New Hampshire
Northern New England Center for Appropriate Technology

ADDRESS OF INSTITUTION (INCLUDE BRANCH/CAMPUS & COMPONENT)

New England Center for Continuing Education
15 Garrison Avenue
Durham, NH 03824

DIVISION (OFFICE) AND DIRECTORATE: Office of Science and Society

PRINCIPAL INVESTIGATOR: Richard M. O'Donnell

SECTION:

PROPOSAL NUMBER: OSS78-19468

FISCAL YEAR: 78

PROGRAM: Science for Citizens

TITLE OF PROJECT: New Hampshire Forums on Energy and the Aging

SUMMARY OF PROPOSED WORK (LIMIT TO 22 PICA OR 18 ELITE TYPEWRITTEN LINES)

Inadequate income, substandard housing, attempts to conserve energy and poor health pose particular hazards for the elderly, making them particularly vulnerable to the impact of the energy crises. NNECAT proposes to conduct a program addressing these problems of the elderly by bringing them and their representatives together with scientific and technical experts in the fields of geriatric medicine, energy efficiency of residential structures, home economics, and local government. The Principal Investigator and a Steering Committee will supervise all four phases of the project: a day-long conference at which the elderly, representatives of medicine and the scientific community, and local officials will exchange and develop information; an outreach and feedback effort through town meetings and sessions at elderly nutrition sites; television and radio presentations; and dissemination of information through Preliminary and Final Reports prepared by project staff. A Task Force will be formed to provide ongoing guidance to policy-makers. Finally, a training program to teach new health and energy-saving techniques to social service personnel dealing with the elderly will be designed and carried out by project staff, with advice from Task Force members. The Northern New England Center for Appropriate Technology is a non-profit organization affiliated with the New England Center of the University of New Hampshire. Active in the promotion of small-scale, low-cost projects that increase individual and community self-reliance in energy, housing, and food production, NNECAT policy is set by its Executive Director in consultation with staff.

PROGRAM APPROVAL: Rochelle Hollander

DATE: 8/10/78

INSTRUCTIONS FOR USE

1. Program Office will complete all items appearing on the first copy; place Proposal Folder copy in the folder; retain Program Suspense copy; and place other copies inside the folder envelope with carbons intact.
2. Division of Grants and Contracts will post award number, amount granted and inclusive project dates on copies 3 through 7 and distribute these copies.

1. PROPOSAL FO[illegible]ER

NSF Form 4, 10-76 Existing stocks will be used.

NATIONAL SCIENCE FOUNDATION

PROJECT SUMMARY

NSF AWARD NO.

NAME OF INSTITUTION (NSF DIRECTORY NAME) University of Colorado at Colorado Springs	ADDRESS OF INSTITUTION (INCLUDE BRANCH/CAMPUS & COMPONENT) Cragmor Road Colorado Springs, Colorado 80907
PRINCIPAL INVESTIGATOR Robert P. Larkin	DIVISION (OFFICE) AND DIRECTORATE OSS/SE SECTION
PROPOSAL NUMBER OSS 78-06684 — FISCAL YEAR '78	PROGRAM Public Understanding of Science

TITLE OF PROJECT

Science and the Elderly: An Informal Instructional Program on Energy and the Environment

SUMMARY OF PROPOSED WORK (LIMIT TO 22 PICA OR 18 ELITE TYPEWRITTEN LINES)

The elderly constitute an increasingly important sector of the public with special interests in the nature and importance of research activities. This project will develop and test a model program to serve these interests.

The University of Colorado at Colorado Springs will develop for local senior citizens a program of informal instruction focusing on energy development and its environmental implications. This energy science program will capitalize on the knowledge and vitality of the many retired scientists in the area as presentors and directors of instructional activities designed for elderly lay people. The program will include workshops, seminars, discussions, demonstrations and field trips which will take place in the area's retirement communities, public halls, research labs, energy industry and other technical facilities.

Preparatory to these events, the project will inventory the scientific skills among the elderly, form a group of 25 retired scientists able to share their expertise with their fellow elders, and coordinate the development by the working scientists of the outreach activities designed to give the elderly an understanding of and, hopefully, involvement in current science issues. Local media will promote and report on the numerous events.

It is hoped that this project can serve as a model for similar programs of science information for the elderly.

PROGRAM APPROVAL

DATE 5/25/78

INSTRUCTIONS FOR USE

1. Program Office will complete all items appearing on the first copy, place Proposal Folder copy in the folder, retain Program Suspense copy, and place other copies inside the folder envelope with carbons intact.
2. Division of Grants and Contracts will post award number, amount granted and inclusive project dates on copies 3 through 7 and distribute these copies.

NSF Form 4, 10/76 Existing stocks will be used.

1. PROPOSAL FOLDER

2

NATIONAL SCIENCE FOUNDATION

PROJECT
SUMMARY

NSF AWARD NO.

NAME OF INSTITUTION (NSF DIRECTORY NAME)
Town of Lexington

ADDRESS OF INSTITUTION (INCLUDE BRANCH/CAMPUS & COMPONENT)
Lexington, Massachusetts 02173

PRINCIPAL INVESTIGATOR
William R. Page

DIVISION (OFFICE) AND DIRECTORATE
OSS/SE

SECTION

PROPOSAL NUMBER
OSS-77-20838

FISCAL YEAR
1977

PROGRAM
SFC

TITLE OF PROJECT
Lexington Forums on Aging

SUMMARY OF PROPOSED WORK (LIMIT TO 22 PICA OR 18 ELITE TYPEWRITTEN LINES)

The Town of Lexington, through its Forum on Aging Committee, will co-sponsor with the American Association of Retired People a forum series on research on aging in late April and May 1978. The Lexington Senior Citizen organizations, the Lexington League of Women Voters, bio-medical and social scientists, and the Lexington churches and synagogues will help to prepare and participate in the forums.

Using an innovative form of "Town Meeting" adaptable to many other settings, the forum series will allow scientists and non-scientists of all age groups to interact. It will elicit diverse views about the ethical appropriateness of biological experiments to modify the rate of human aging; the appropriate priority of a national goal of extending the healthy middle years of life; the social consequences of progress toward this goal; diverse views on the likelihood of and the consequences of reversing certain forms of senility, of reducing the frequency of major disabilities, and of influencing the rate of human aging through nutrition and preventive medicine. The discussion will include assessment of the rate of progress of biomedical research on causes of aging and ways in which that rate could be influenced.

This project will help Lexington citizens reach informed decisions on issues relevant to aging. Greater understanding of science involved in human aging will give policy guidance to Lexington citizens, Town Meeting Members and other elected officials in considering government expenditures for health and other human services.

PROGRAM APPROVAL

DATE
7/26

INSTRUCTIONS FOR USE

1. Program Office will complete all items appearing on the first copy, place Proposal Folder copy in the folder; retain Program Suspense copy, and place other copies inside the folder envelope with carbons intact.
2. Division of Grants and Contracts will post award number, amount granted and inclusive project dates on copies 3 through 7 and distribute these copies.

ITEM 24. OFFICE OF CONSUMER AFFAIRS

JANUARY 31, 1979.

DEAR SENATOR CHILES: In response to your request, I am enclosing copies of the summary of the United States Office of Consumer Affairs activities on behalf of the elderly during 1978. We are pleased to have the opportunity to contribute to the Senate Special Committee on Aging annual report.

Sincerely,

ESTHER PETERSON,
Special Assistant to the President for Consumer Affairs.

Enclosure.

REPORT OF ACTIVITIES OF THE U.S. OFFICE OF CONSUMER AFFAIRS DURING 1978 RELATING TO OLDER AMERICANS

The U.S. Office of Consumer Affairs (US/OCA) serves as the staff of the Special Assistant to the President for Consumer Affairs and advises Federal agencies on consumer related policies and programs. US/OCA encourages and assists in the development of new consumer programs, makes recommendations to improve the effectiveness of Federal consumer programs, cooperates with State agencies and voluntary organizations in advancing the interests of consumers, promotes improved consumer education, handles consumer complaints, recommends legislation and regulations of benefit to consumers and encourages productive dialog and interaction between industry, government, and the consumer.

Major activities have primarily focused on consumer advocacy, consumer education and information, and planning and analysis. While these activities in general are initiated on behalf of all consumers, it should be noted that the elderly consumer shares fully in the benefits of US/OCA programs.

Highlighted below are major activities having the greatest impact on older Americans.

CONSUMER ISSUES

Credit

US/OCA urged the Federal Home Loan Bank Board to develop standards for reverse annuity mortgages instruments. Reverse annuity mortgages are specifically designed to aid elderly homeowners. Under RAM, a person is able to receive monthly supplemental income allowances from an annuity purchased by a loan secured with the equity in his/her home, thus allowing persons to capitalize on their major lifetime investment. As a result of US/OCA and other public commentary, the FHLBB has adopted minimum regulatory requirements for RAM and has imposed specific disclosure and other consumer protection standards for this type of alternative mortgage instrument.

Insurance

US/OCA and the National Consumers League cosponsored a conference on life insurance which featured discussion of major consumer issues in life insurance, including cost disclosure, policy language simplification, and marketing. Conference proceedings are available from US/OCA. In addition, US/OCA testified during life insurance cost disclosure hearings conducted in August 1978 by the House Committee on Interstate and Foreign Commerce, Subcommittee on on Oversight and Investigations.

Labeling

In conjunction with US/OCA's participation in the Food and Drug Administration's current regulatory proceeding on food labeling, particular attention is being focused on the expressed needs of older Americans. Our objective is to develop labeling information which will be informative and useful but not likely to increase the price of the items to be purchased.

Transportation

US/OCA has obtained a commitment from the American Express Co. to conduct a survey in 1979 on problems that consumers, including elderly consumers, have in obtaining information on the most economical air charter and scheduled air service available.

US/OCA has asked the Interstate Commerce Commission to initiate proceedings on proposed changes in intercity bus fare regulations. Both consumers, especially low-income consumers, and the intercity bus industry could benefit from regulations allowing increased flexibility in reducing bus fares and setting charter prices. US/OCA urged the ICC to open rulemaking proceedings to consider changes in ICC's proposed by Trailways, Inc.

Specifically, Trailways has asked that the bus industry have the authority to offer fare reductions without previous notice to ICC and have them take effect on the date they are published, rather than requiring advance approval and advance publication of reduced fares, as is the current practice. ICC would have 30 days to suspend such reductions if they were predatory, i.e., designed to eliminate competition. Trailways foresees more competition between buses, railways and airlines as a result of its proposals.

Trailways has also asked the ICC for permission to negotiate charter fares instead of publishing set prices.

US/OCA said these requests from Trailways provide the ICC with an excellent opportunity to review some of its regulations that affect the bus industry and its intercity ridership, the largest percentage of whom earn less than $5,000 per year. Many of them elderly.

US/OCA did not take a stand on the substance of the Trailways request because the ICC requested comments only on the issue of whether the Trailways petition for rulemaking should be considerd. US/OCA noted however, that under the proposal, certain undesirable pricing tactics could harm competition and that pricing discrimination may be at issue under the negotiated charter pricing request. In asking ICC for a formal rulemaking proceeding on the Trailways petitions—which would include opportunity for participation by all affected parties—US/OCA pointed out that what may be needed to minimize these potential problems "is proper enforcement instead of what frustrates price competition."

Health

US/OCA has supported through written commentary and public statements efforts to control the spiraling cost of hospital care. Additionally, US/OCA plans to support proposed HEW regulations to require public representation on insurance boards that process medicare and medicaid claims.

Drugs

Under a contract with US/OCA, the Virginia Citizen Consumer Council prepared a report on the extent of prescription drug price advertising practiced by drug stores in Virginia following the Supreme Court decision which struck down a Virginia law which prohibited such advertising. The report will be used to assess the need for further action by government in bringing consumers, including elderly consumers, the benefits of prescription drug price advertising and price competition.

In conjunction with HEW's efforts to promote the use of generic drugs, US/OCA submitted supporting comments on the draft of the HEW produced "Guide to Prescription Drug Prices." In addition, attempts are being made through written commentary and public testimony to increase advertising of prescription drug prices, particularly for health maintenance drugs. Plans are also underway to undertake a survey of prescription drug prices with specific solicited input from senior citizens.

Hearing-Impaired

US/OCA convened meetings between representatives of the telephone industry and representatives of hearing-impaired consumers, including the elderly handicapped, and is working with both groups to establish a continuing vehicle for dialogue on the subject of how technology can improve and assist rather than impair and complicate the daily functioning of the hearing-impaired.

The office funded the installation of an induction-loop system in the HEW North Building auditorium. This system greatly improves speaker audibility for wearers of hearing aids equipped with telephone switches.

Energy

US/OCA petitioned to intervene in a proceeding before the Federal Energy Regulatory Commission (FERC), the outcome of which will have a major impact on elderly utility consumers around the country. The proceeding, which is still underway, concerns an application of the Public Service Co. of New Hampshire (PSNH) to include construction work in progress (CWIP) in its rate base. Essentially, PSNH is seeking to make its present customers pay a return on facilities under construction and therefore not yet generating electricity. Although the final decision in this case will directly affect only New Hampshire consumers, it could establish a precdent that would be followed by state regulatory commissions around the country. Hence, the outcome of this case could affect utility users nationwide.

US/OCA has opposed the PSNH application because rate base treatment of CWIP discriminates against present customers in favor of future customers. The elderly, in particular, would be forced to pay for generating plants from which they may never receive electric service. US/OCA has called the Commission's attention to this intergeneration equity problem in the direct testimony of three expert witnesses, during 3 weeks of hearings on the case, and in a brief and reply brief. A decision in the case is expected soon.

US/OCA also plans to facilitate the representation of utility consumer interests at the state level by establishing an information exchange network for State utility consumer advocates, and by developing and distributing information related to the Public Utility Regulatory Policy Act of 1978 (PURPA). PURPA establishes 11 rate design and utility service standards which must be considered for implementation by State regulatory commissions within the next 2 years. By faciliating the representation of consumer interests in utility rate proceedings and PURPA hearings, US/OCA can help to control the increase in utility rates and improve the quality of utility service. Since electric and gas service are basic necessities of life, the elderly are directly benefitted by improved service and slower rate increases.

OUTREACH

Conferences and Technical Assistance

Besides providing information on an individual basis, US/OCA has participated in national, regional, and State conferences and workshops designed to address issues affecting low income and elderly consumers. In addition to providing materials and information regarding possible funding sources and technical assistance, US/OCA has continued to alert these groups to proposed legislation, regulations and policies that may impact on them.

US/OCA sponsored a consumer education "catch-up" conference which brought together educators, community leaders and representatives from senior citizen organizations. Many issues presented impacted on elderly consumers. Conference proceedings are available from US/OCA.

The office is currently developing workshops and serving on the planning committee for the May National Conference on the Black Aged to be held in Jackson, Miss. The theme is "protecting the consumer rights of the elderly: rural and urban."

US/OCA will cosponsor with Howard University a spring conference focussing on the needs of low income consumers. The conference is being designed to train grassroot program directors, highlight successful community based consumer programs and provide up to date information on consumer legislation and issues.

Information and Education

In addition to carrying articles in every issue of general interest to all consumers, "Consumer News" focused on Federal activities of special concern to the elderly. A few examples: Federally funded nutrition and transportation programs high costs of medical care, tips on energy conservation, widowers' benefits, and memorial societies. "Consumer Register," which carries summaries of Federal regulations, includes material of special interest to older Americans such as those dealing with social security, nursing homes and prescription drugs.

"Dear consumer" columns, which are provided as a public service to more than 7,000 weekly newspapers, have dealt with topics that primarily concern older Americans. US/OCA's 4-minute Public Service Radio program "HELP," sent to over 1,200 radio stations, frequently has programs designed for the elderly. "HELP" and "dear consumer" have dealt with such specific topics as: retirement living, concerns for older women, pensions, Gray Panthers, nursing homes, and elderly taxpayers.

US/OCA's "Directory of Federal, State and Local Consumer Offices" includes a listing of toll-free telephone lines in operation to help facilitate consumer contacts with these offices. The directory, now being updated, also includes a listing of Federal information centers, Federal consumer information centers and State public utilities commissions. These will insure that the directory is of special assistance to the homebound and/or handicapped consumers. The directory will be available soon.

US/OCA prepared "A Consumer Shopping List of Inflation Fighting Ideas," a 16 page tabloid newspaper with 140 ideas on stretching dollars. It covers ideas in food buying and preparation, health services, housing and energy. The guide has provided useful information for elderly consumers. Copies of the guide are available from US/OCA.

INTRAGOVERNMENTAL ACTIVITIES

Consumer Complaints

A four-phase study to improve complaint handling in the public and private sectors funded by US/OCA has been completed. The study should serve as the catalyst for substantive changes in procedures and will enhance the impact complaint data has on management directives and formulation of policy.

Many of the approximately 20,000 complaints received by US/OCA during 1978 were from elderly consumers. About one-fourth of these complaints were referrals from the White House, members of Congress, and other Federal agencies. Each complaint is given careful consideration and brought to the attention of the appropriate Federal, State, county or city government agency, trade association, or business firm that can be of assistance to the consumer. A special effort is made to be of direct help to senior citizens when it is possible.

Interagency Committees

US/OCA was represented on the following Interagency Committees which have special impact on the elderly:

Planning committee of the 1981 White House Conference on Families. The conference will highlight the special needs of infants, children, young adults and the elderly which make up the extended family.

HEW Secretary's task force on the Age Discrimination Act of 1975. The task force was responsible for developing general guidelines. Scheduled to go into effect January 1979, the law provides that no person can, on the basis of age, be denied the benefits of or be subjected to discrimination under any program or activity receiving Federal financial assistance.

Policy group of the HEW task force on deinstitutionalization of the mentally ill and mentally retarded. The task force developed Department strategy on deinstitutionalization of community care and treatment.

Congressional Black Caucus "brain trust" on the elderly. Among other things, the brain trust assisted the caucus in developing legislation to benefit minority and poor elderly citizens.

University of Pittsburgh's National Consumer Advisory Council. The council advised the university in carrying out its Administration on Aging grant to research the fraud problems of the elderly.

Intra-HEW nutrition coordinating committee which considers broad nutrition needs of Americans including the elderly.

Interagency energy and the elderly committee which provides members with information on Federal programs and activities designed to lessen the impact of the high cost of energy on low income individuals, including the elderly.

ITEM 25. OFFICE OF PERSONNEL MANAGEMENT

JANUARY 15, 1979.

DEAR MR. CHAIRMAN: This is in response to your letter of December 1, 1978, inviting us to submit a summary of our major actions during 1978 related to aging. Our report on these activities is enclosed and is entitled "Major 1978 Activities of the Civil Service Commission Affecting Rights and Benefits of Older Americans."

A most significant piece of legislation enacted this year affecting older workers was P.L. 95–256, enacted 4–6–78, amending the civil service retirement law to remove the mandatory separation requirement of Federal employees who attain age 70 with 15 years of creditable Federal service. This amendment was effective September 30, 1978. The Commission strongly endorsed the elimination of age 70 mandatory retirement since it believed that the decision to retire should be left to the individual as long as he or she is capable and has the ability to perform the duties of a position. Furthermore, as a matter of public policy, age should not be a determinant in either entering or leaving government employment unless it can be clearly demonstrated that it is a bona fide occupational requirement. It is not expected that the mandated study due January 1, 1980 will indicate any adverse impact on Federal personnel management as a result of enactment of P.L. 95–256.

In addition, P.L. 95–437, Federal Employees Part-Time Career Employment Act of 1978, was enacted, and older people are among those who might benefit particularly from this legislation. A copy of a recent report on part-time employment in the Federal Government is enclosed for your interest.

Our 1979 activities in this area should continue to focus on efforts to assure nondiscrimination on account of age in employment and to provide services and assistance related to administration of the civil service retirement system and the retired Federal employees health benefits program.

We hope this report will be a useful addition to your committee's publication. Thank you for the opportunity to participate. If any other information is needed, please let me know.

Sincerely yours,

ALAN K. CAMPBELL, *Director*.

Enclosures.

MAJOR 1978 ACTIVITIES OF THE CIVIL SERVICE COMMISSION AFFECTING RIGHTS AND BENEFITS OF OLDER AMERICANS

ADEA (AGE DISCRIMINATION IN EMPLOYMENT ACT) PROGRAM

The Commission (and Federal agencies) continued the program to assure nondiscrimination on account of age under the act, as amended, and implementing Commission regulations. This included policy interpretations; processing of complaints, appeals, and notices of intent to file civil actions under ADEA; program evaluation; statistical data program development; Department of Labor and other liaison-coordinative relationships; orientation, training, and other efforts to inform and publicize; and other ongoing activities.

DEVELOPMENTS OF PARTICULAR NOTE IN 1978

ADEA Amendments of 1978, Public Law 95–256, became effective in the Federal employment sector on September 30, 1978. Briefly summarized, the law:

—Retained the minimum age limit of 40 for ADEA protection against discrimination on account of age;

—Removed the upper age limit for ADEA protection (which presently is age 40 to less than 70 for employees and age 40 to less than 65 for applicants);

—Specifically repealed the title V mandatory age-70 retirement provision (i.e., mandatory retirement at age 70 with 15 years of service or after age 70 upon completion of 15 years service);

—Specifically repealed title V prohibitions against permanent appointments for persons age 70 or more;

—Did *not* change (a) statutory "early" mandatory retirement provisions involving Isthmus of Panama, Alaska Railroad in Alaska, certain CIA, or Foreign Service employees (although we should note that the Foreign Service statutory requirement for early retirement is in litigation now); or (b) statutory provisions concerning age limits for appointment and retirement of certain air traffic controllers, park police, and certain law enforcement and firefighter personnel;

—Did *not* change title V optional retirement provisions.

Reorganization.—The Civil Service Commission completed its final year of responsibility for administering and enforcing the ADEA in the Federal employment sector, a responsibility established in 1974 when the ADEA was amended to include coverage of public as well as private employment. As a result of Reorganization Plan No. 1, the Commission's ADEA responsibilities transferred to the Equal Employment Opportunity Commission (EEOC) effective January 1, 1979.

Publication.—In cooperation with EEOC, work is expected to continue on the development of age-related work force statistics. A first major publication on this subject was issued this year in the Civil Service Commission. It is entitled "Age and Federal Employment—An Overview," and is based on December 1974 Federal civilian work force statistics. A copy was sent to the committee earlier in the year, and another is herewith enclosed.

Age Discrimination Complaints.—The Federal discrimination complaints system has been available to individual Federal civilian employees and applicants in the ADEA-protected age group since the May 1, 1974 effective date of the 1974 ADEA amendments. Age discrimination was the subject of about 13 percent of formal discrimination complaints filed by individuals in fiscal year 1977 (latest information available).

CIVIL SERVICE ANNUITANTS

Pursuant to 5 U.S.C. section 8340, the annuities of retirees and survivor annuitants under the Federal civil service retirement system were increased to keep abreast of changes in the cost-of-living. Annuities were increased by 2.4 percent, effective March 1, 1978, and again by 4.9 percent, effective September 1, 1978.

To comply with the final opinion and order issued December 22, 1977, in the case *of Shannon* v. *U.S.C.S.C.*, No. C-76-1364-SW, U.S.D.C., N.D., California, the Commission prepared interim regulations establishing administrative procedures for the recovering of erroneous payments to annuitants made in the course of its administration of civil service retirement, Federal Employees' health benefits, Federal employees' group life insurance, and retired Federal employees' health benefits programs.

The Commission approved 10 new comprehensive medical plans (health maintenance organizations) for participation in the Federal employees health benefits (FEHB) program. These plans provide health services on a prepaid basis to subscribers living in the specific geographic areas covered by the plans. During the annual FEHB open seasons, employees and annuitants can enroll in any plan for which they are eligible, One of the new plans was the Blue Cross network, composed of 18 plans.

OTHER NEW LAWS ENACTED AFFECTING RETIREMENT, LIFE INSURANCE, OR HEALTH BENEFITS

P.L. 95-366, enacted 9-15-78, amending title 5, U.S.C., to authorize the Civil Service Commission to comply with the terms of a court decree, order or property settlement in connection with the divorce, annulment, or legal separation of a Federal employee or annuitant who is under the civil service retirement system.

P.L. 95-368, enacted 9-17-78, establishing uniformity in benefits and coverage under the Federal employee's health benefits program. Effective for a 5-year period commencing January 1980, carriers are required to pay or reimburse for certain treatment or services rendered in a medically underserved area by any type of practitioner, if the practitioner is licensed in that State to provide such treatment or services and if the health benefits contract provides payment or reimbursement for the type of treatment or services rendered.

P.L. 95-382, enacted 9-22-78, amending title 5, U.S.C., to provide that Japanese-Americans shall be allowed civil service retirement credit for time spent in World War II internment camps.

P.L. 95-454, enacted 10-13-78, amending title 5, U.S.C., to reform the civil service laws. The act, under section 303(g)(2), includes a provision to protect the pension rights of reserve officers who currently qualify for retirement but have not yet reached the mandatory age of 60 years. Section 412 adopts the House amendment providing for early retirement for those employees removed from the

Senior Executive Service for less than fully successful performance. In addition, the law incorporates certain new technical and conforming amendments.

P.L. 95-519, enacted 10-25-78, clarifying the status of the Librarian of Congress under subchapter I or chapter 63 of title 5, U.S.C., relating to annual and sick leave. The law amends section 8339(m) of title 5, U.S.C., by adding at the end thereof the following new sentence: "For the purpose of this subsection in the case of any such employee who is excepted from subchapter I of chapter 63 of this title, the days of unused sick leave to his credit include any unused sick leave standing to his credit when he was excepted from such subchapter."

P.L. 95-583, enacted 11-2-78, amended title 5, U.S.C., to provide that employees who retire after 5 years of service, in certain instances, may be eligible to retain their life insurance and health benefits coverage. For retention purposes, the law requires participation in the health and/or life insurance programs for the 5 years of service immediately preceding the date of retirement, or for the full period or periods of service during which the employee was entitled to participation, if less than 5 years. The law became effective upon enactment.

COMMISSION PARTICIPATION WITH GROUPS ON AGING

The Commission continued to participate in activities dealing with problems of older Americans. For example, in cooperation with the Administration on Aging, the Commission continued to make certain information and referral services available in its nationwide job information center network for use of older Americans.

INTERGOVERNMENTAL PERSONNEL PROGRAMS

Under the Intergovernmental Personnel Act (IPA), the Office of Personnel Management (OPM) is authorized to make grants to assist State and local governments and Indian tribal governing bodies to strengthen their central management capability by improving their personnel systems and training their professional, administrative, and technical employees.

State and local officials decide which of their management improvement needs can be met by applying for available IPA funds. OPM's approach is to encourage State and local governments to cooperate in the identification of management improvement needs and to support those projects which the jurisdictions determine are the most important within the confines of the law and national policy.

There have been some IPA grant projects which deal with issues and programs of interest to the elderly. One such project currently underway provides workshops for new directors of area agencies on aging. These sessions cover the directors' developmental needs in areas of intergovernmental realtions and regulatory affairs on behalf of a locale's older Americans. The OPM is funding this project in conjunction with a grant from the Department of Health, Education, and Welfare's Administration on Aging.

Another IPA-funded project involves the efforts of the National Conference of State Legislatures (NCSL) to provide training, information, and guidelines to State legislators and staff on pension issues and pension reform. This project aims to educate those who control State pension plans to improve their fiscal integrity, effectiveness, and fairness. This benefits the potential retirees as well as the public at large who support such systems.

Over the years, the IPA grant program has funded many general personnel management projects, some of which have involved various aspects of retirement. One such project carried out by the State of Connecticut enabled the State's larger agencies and municipalities to sponsor brief preretirement education courses for older employees, thereby enhancing their chances of experiencing well adjusted and rewarding retirements.

The Intergovernmental Personnel Act also authorizes the temporary exchange of employees between Federal agencies and State, local, and Indian tribal governments and institutions of higher education. Approximately 1,200 such temporary assignments occurred during fiscal year 1978. Program data indicates a high rate of participation by senior employees (GS-13 level and above), so it can reasonably be assumed that these have included significant numebrs of older workers. The OPM is presently working to improve its data base on mobility program activities. Participant age is one of the variables being considered for inclusion in the new data base.

Attachments.

CIVIL SERVICE COMMISSI
Washington, D.C., December 28, 1

MEMORANDUM FOR HEADS OF DEPARTMENTS AND AGENCIES

Earlier this year we asked each agency for a series of progress reports on implementation of the President's September 1977 message on expanding permanent part-time employment opportunities. The initial agency reports have now been compiled and a summary is attached for your information.

I am sure that you are as encouraged as I am by the progress made thus far. We are also cognizant of the problems identified and will be working to overcome them.

The recently enacted Federal Employees Part-time Career Employment Act of 1978 gives us all additional responsibilities for part-time employment and I ask your continued cooperation, as we move to implement this legislation in the months ahead.

ALAN K. CAMPBELL, *Chairman.*

Attachment.

PERMANENT PART-TIME EMPLOYMENT IN FEDERAL AGENCIES, SEPTEMBER 1977–JULY 1978

EXECUTIVE SUMMARY

Part-time employment in the Federal Government has substantially increased during the first phase of a program to provide more opportunities for people who need to work less than full time.

A special Civil Service Commission survey of the largest Federal agencies shows that over 6,000 permanent part-time position were established in the first 10 months following President Carter's September 1977 directive to Federal agencies to open up more part-time jobs.

Agencies cited a variety of management benefits from greater use of part-time workers including improved productivity and reduced overtime. Problems were encountered in identifying "true" part-time employment candidates and in dealing with certain "per capita" costs associated with employing extra workers. Actions are underway to overcome these problems.

The personnel ceiling system was most frequently cited as the major obstacle to further expansion of part-time employment. Because of the ceiling requirement that part-time and full-time employees count essentially the same against an agency's personnel authorization, many managers feel they are losing staff resources by employing part-time workers. Recent congressional and administration actions will change this arrangement over the next 2 years. Beginning in October 1980, agencies will be given personnel ceilings which count part-timers only according to the proportion of a full-time schedule they work. Five agencies are using this system on a test basis during fiscal year 1979.

On September 16, 1977, President Carter directed Federal agencies to expand permanent part-time employment opportunities. This effort is aimed at giving older people, those with family responsibilities, the handicapped, and students greater opportunities for Federal career employment.

In February, 1978, the Civil Service Commission (CSC) asked Federal agencies employing more than 2,500 workers for a series of reports on their actions to implement this directive. The first progress reports from these agencies covering the period September 1977 through July 1978 have now been reviewed and analyzed. Major highlights of this first survey of Federal part-time employment follow.

NEW PART-TIME JOBS ESTABLISHED

Agencies were asked to identify by occupation and grade each new part-time permanent position established in headquarters and field activities from September 16, 1977, through July 31, 1978. Agencies reported establishing over 6,000 new jobs in this category during this period (see detailed table attached). In a departure from past experience about 30 percent of the new jobs were in pay grades GS–5 or above. Over 5 percent of the new part-time jobs were at grades GS–10 and above.

Expansion of part-time employment in higher graded professional and administrative jobs is a major priority of the recently enacted Federal Employees Part-time Career Employment Act of 1978. As recently as April 1976, a CSC report to the House Post Office and Civil Service Committee showed that only 20 percent of the Federal part-time work force served at GS–5 or above.

The Department of Health, Education and Welfare accounted for over a fifth of the new part-time jobs. Other large-scale increases came from the Veterans Administration and the Department of the Interior.

MANAGEMENT PERSPECTIVE

Many agencies reported important management benefits from greater use of part-time workers. The Navy Department reported increasing part-time employment to improve productivity in its commissary and exchange system. The Naval Supply Systems Command initiated a cost control staffing program designed to reduce expenses by better matching employee working hours with peak customer demands. By using more part-time workers, Navy stores have been able to better meet peak demands without increasing costs.

The International Communications Agency reported that greater use of part-time employment improved the agency's ability to fill difficult jobs. The agency cited employment of part-time operators for the optical character reader typewriters it uses to transmit the daily agency wireless file to overseas posts. This is a 12-hour per day operation which does not require continued presence by the same operators. The agency believes that part-timers are better able to perform this tedious and repetitive work because of their shorter daily exposure time.

Other benefits were identified. Several agencies reported using part-time employment as an alternative to costly overtime. EPA indicated it was able to retain several hard-to-replace engineers by offering them part-time employment upon their return from maternity leave. TVA reported that establishing more part-time positions had improved the agency's ability to attract women and minorities to its white collar work force.

CURRENT EMPLOYEE INTEREST IN PART-TIME

Agencies were also asked to identify interest levels of current full-time employees in switching to part-time work schedules. This area was emphasized because of the widespread belief that many full-time employees would prefer to work part time if given the opportunity.

Most agencies conducted at least partial surveys of their work force on this question. (Many of the surveys had not been completed at the time of the report.) Interest levels varied considerably. HEW reported that in a February 1978 survey of 2,200 workers at a Social Security Administration Program Center, 73 (3.5 percent) employees expressed interest in switching to part-time; 32 of these employees were at grades GS-7 or above. The Veterans Administration reported that a total of 1,236 employees expressed interest in switching to part-time employment in an agencywide survey. Of that number 491 actually shifted to a part-time schedule. In the Treasury Department, 1,424 employees expressed interest in switching. In VA, Treasury, and most other agencies the majority of interested employees were at grades GS-6 and below.

Several agencies reported establishing formal policies to honor employee requests to shift from full time to part time whenever the work situation permits.

AGENCY EVALUATIONS OF PART-TIME EMPLOYEE EFFECTIVENESS

Few agencies reported completing special surveys of part-time employee effectiveness, although several were in the planning stages.

HEW reported the results of a survey of supervisors of 571 part-time employees conducted by the Social Security Administration Federal women's program. The supervisors stated that almost 40 percent of the part-timers performed work of a higher quality than comparable full-time employees and 35 percent had more positive attitudes about their work. Overall 97 percent of the supervisors surveyed responded favorably to their experience with part-time employees.

The Treasury Department reported that after reviewing the effectiveness of part-time workers, some managers in the agency had decided to increase part-time hiring goals. The Department of the Army also noted that morale and productivity are generally high among its part-time employees.

FUTURE DIRECTIONS

The concluding portion of the survey dealt wtih changes in Government-wide policies, regulations or laws which would increase permanent part-time employment opportunities.

Certainly the major factor affecting part-time employment in the months ahead is the recently enacted Federal Employees Part-time Career Employment Act of 1978 (P.L. 95–437). This legislation requires agencies to operate continuing part-time employment programs which must include goals and timetables for part-time hiring, position review procedures for identifying part-time vacancies, and special part-time job announcement procedures. The new Office of Personnel Management is charged with overseeing this effort, providing technical assistance to agencies, and conducting research on part-time employment.

A key feature of this legislation changes the personnel ceiling system and will thereby remove what agencies identified as the chief obstacle to expanded part-time employment. Because of present ceiling requirements that part-time and full-time employees count essentially the same against an agency's personnel authorization, many managers feel they are losing staff resources by employing part-time workers. The new full-time equivalent (FTE) system, mandated for Government-wide use in 1980 by P.L. 95–437, will count part-time employees for ceiling purposes only according to the percentage of a full-time schedule they work.

Although most provisions of the new law will not go into effect until April 1979, various actions begun under the President's initiative are already laying the groundwork. Five agencies (VA, FTC, GSA, EPA and Export-Import Bank) have begun testing the FTE ceiling system. The final shape of this system, which has implications far beyond part-time employment, will therefore be determined after actual use. The FTE test also emphasizes expanding part-time employment opportunities and should provide valuable insights on this progress.

In addition to the nationwide effort underway in the five FTE test agencies, other agencies are conducting experiments on a regional basis. The Social Security Administration has recently begun an experiment in two regions designed to give field managers broader flexibility in setting work schedules and using part-time employees.

Along with these agency efforts, certain actions have been taken by the Civil Service Commission to improve Government-wide part-time employment policies and procedures. When contacts with potential applicants indicated many were unaware that the Federal Government employed part-timers, recruiting aids were developed to correct this impression.

Changes have also been made in the Federal job application form (SF–171) to improve screening of part-time applicants. In place of a simple "yes"–"no" question on availability for part-time work, the new form asks applicants to indicate availability for specific hour ranges of part-time jobs: 0–20 hours, 21–31 hours, 32–39 hours. This more refined screening process is designed to deal with the longstanding problem of distinguishing between candidates who really want to work part time, and those who are seeking a "foot in the door" to full-time employment.

The proper role of part-time employment in the organization was identified as a concern in the survey and is also receiving attention. The Civil Service Commission has recently surveyed several hundred part-time employees, their supervisors, and comparable full-time workers on their roles and relationships. This survey is expected to provide important information on the dynamics of the part-time work force and the optimal work situations for employing part-timers. Several other agencies are planning or have begun similar research efforts. A CSC clearinghouse is being set up to disseminate information on these and future research efforts.

Some problems identified by agencies are more difficult to address. Chief among these are the extra "per capita" costs (e.g., security clearances, space and equipment, training, supervision, etc.) which accrue when agencies use more employees who work fewer hours.

Although progress will undoubtedly be affected by Federal hiring limitations and budget restrictions, most agencies appear optimistic about future expansion of part-time opportunities in their work force. In responding to the survey several expressed the belief that part-time employment should not be increased merely for the sake of increase, but because organizational needs can be met and additional resources can be tapped. Others indicated that once management is more familiar with part-time employment and the ceiling system is changed, opportunities are bound to increase. These areas will receive priority attention as the Office of Personnel Management moves to implement the Federal Employees Part-Time Career Employment Act of 1978 in the months ahead.

NEW PERMANENT PART-TIME JOBS ESTABLISHED IN FEDERAL AGENCIES WITH MORE THAN 2,500 WORKERS, SEPT. 16, 1977 TO JULY 31, 1978

Agency	Total	Grade levels/equivalents: GS–1 to 4	GS–5 to 9	GS–10 and above
NASA	10	4	2	4
EPA	30	15	12	3
FDIC	15	15		
NRC	9		8	1
CSC	123	92	16	15
GSA	49	33	14	2
TVA	131	[1] 131		
ICA	10	10		
Justice	135	91	40	4
Agriculture	301	213	72	16
Interior	1, 276	807	439	30
SBA	27	[1] 27		
Air Force	434	419	7	8
Army	485	436	25	24
Navy	[2] 26	15	7	4
Other Defense	6	6		
Treasury	170	93	71	6
HUD	26	8	8	10
HEW	1, 348	605	561	182
Labor	23	11	5	7
VA	1, 320	1, 117	159	44
Transportation	44	22	17	5
Commerce	162	113	25	24
AID	73	26	41	6
Energy	28	21	3	4
State	53	33	16	4
Smithsonian	18	[1] 18		
Total	6, 332	4, 381	1, 548	403

[1] Grade level distribution unspecified.

[2] Figures do not include positions in Navy commissaries and exchanges.

ITEM 26. PENSION BENEFIT GUARANTY CORPORATION

JANUARY 15, 1979.

DEAR MR. CHAIRMAN: This is in response to your December 1, 1978, request for a summary of the Pension Benefit Guaranty Corporation's (PBGC) activities on aging.

Title IV of the Employee Retirement Income Security Act of 1974 (ERISA) established PBGC to provide termination insurance covering most defined benefit plans. On termination of a covered plan PBGC guarantees the payment of benefits vested under the terms of the plan within limits specified in ERISA. This includes payments to surviving beneficiaries under options such as joint and survivor annuities, as well as to the participants when they reach retirement age.

Since almost all terminating plans filing with PBGC have sufficient assets to meet guaranteeable benefits, these cases are expedited to allow assets to be distributed to participants and beneficiaries with a minimum of delay. In those cases with insufficient assets, top priority is given to maintaining continuity of benefit payments. If plan assets are not adequate to avoid benefit interruption, PBGC assumes trusteeship quickly so that benefits to the retirees and their beneficiaries can be continued.

As of September 30, 1978, there were approximately 266 plans under PBGC trusteeship covering approximately 45,000 participants and beneficiaries. Under these plans, PBGC has paid $1,783,583 in benefits monthly to 14,394 individuals. Under many of these plans, the participants and beneficiaries would not receive their promised benefits if PBGC were not in existence.

Five of the plans under PBGC trusteeship are multiemployer plans, where PBGC exercised its discretion to guarantee benefits. (Under the Employee Retirement Income Security Act of 1974 (ERISA), as amended, mandatory coverage of multiemployer plans does not become effective until July 1979.) Eleven additional multiemployer plan termination requests are currently under review by PBGC.

In addition, PBGC is charged by ERISA with the duty to provide advice and assistance to individuals regarding establishment of individual retirement accounts (IRA's) or other retirement savings, and the desirability, in particular cases, of transferring an employee's interest in a qualified retirement plan to a form of individual retirement savings upon termination of employment. Booklets on this subject are available from the PBGC and the Federal Trade Commission (FTC). (The FTC booklet may be obtained from PBGC.)

Any elderly person may write to PBGC, Office of Communications, Room 7100, 2020 K Street N.W., Washington, D.C. 20006 for information on pension protection under ERISA for terminating defined benefit pension plans, or they may call PBGC on 202-254-4817.

We hope this information will be helpful to you.

Sincerely,

MATTHEW M. LIND,
Executive Director.

ITEM 27. POSTAL SERVICE

JANUARY 15, 1979.

DEAR MR. CHAIRMAN: This responds to your letter of December 1, 1978, requesting an update of last year's report to your committee on Postal Service programs as they affect the elderly.

The most significant undertakings by the Postal Service which are of special benefit to the aging are our civil and criminal enforcement activities under the laws prohibiting the use of the mails for fraudulent schemes. The swindlers who engage in these frauds often find that senior citizens are the most inviting targets because many live alone and often because of reduced ability to protect themselves. Moreover, elderly persons living on fixed or reduced incomes suffer more severely when defrauded by these schemes than younger persons better able to earn the means to support themselves.

The Congress has given the Postal Service some effective tools to fight this kind of preying on the weak or unsophisticated. The criminal mail fraud statute, 39 U.S.C. 1341, is the oldest and perhaps the most important consumer protection law. It provides penalties of up to 5 years in prison and a $1,000 fine for the use of the mails to further any fraudulent scheme. The civil false representation statute 39 U.S.C. 3005, enables the Postal Service, after a hearing, to stop the delivery of mail pertaining to a "scheme or device for obtaining money or property through the means of false representations." Section 3007 of the same title authorizes the Postal Service to go to court to get a temporary restraining order against a person suspected of a violation, pending action on the mail stop order. The stop order can be a very effective way to put fraudulent schemes out of business, short of criminal prosecution.

In enforcing these laws, the Postal Service has found many schemes in which elderly individuals are intended victims. Many of these involve particularly deplorable attempts to exploit the aging citizen's entitlement to Government benefits. Enclosed are brief summaries of some of our recent specific activities in criminal and civil enforcement involving schemes against senior citizens. Some of this material was shared with the committee this past summer but has been put in updated form. In addition to enforcement activities, the Postal Inspection Service devotes numerous hours toward educational efforts to prevent schemes of this character. Postal Inspectors frequently address community groups and appear on radio and television to try to alert elderly and other citizens about the dangers of these schemes, ways to avoid them, and steps to report them to the authorities.

The aging also are vitally interested in Postal Service efforts to combat the theft of mail after delivery. These thefts often focus on social security and other retirement checks as well as food stamp and other benefit documents received by many older people. A brief summary of recent theft prevention efforts also is enclosed. With recent changes in the Food Stamp Act, the convenience of mailing food stamps directly to the recipients, which is perhaps of most benefit to the elderly and infirm, has become easier to achieve. Every effort is being made to assure the security and reliability of the mail-out program.

The Postal Service has mail-out programs of its own, designed to help the elderly and others who do not get out frequently to go to their post office. One is the Stamps by Mail program, now in its seventh year of operation. Postage-paid forms are available enabling the customer to order stamps and stamped envelopes, enclosing a check including a 40 cent fee to cover handling. The order is filled by mail within 3 days. The consumer service card program, also available to all customers, provides another opportunity for the elderly and others who find it difficult to get out to the post office, to handle problems by mail. These cards, furnished by mail carriers, bring to the attention of Postal Service headquarters and the local post office any complaints or requests the customer wants to register concerning mail delivery or other services.

A much different type of program aiding the elderly, the handicapped, and those who live alone is the continuing "Postal Alert" or "Operation Alert" program. This program is a partnership effort between the Postal Service and a local community group or agency. Letter carriers keep a special watch on mail delivery boxes marked with a bright red or orange sticker given to customers registered in the program. If mail is not picked up from the mailbox in a reasonable time, the Postal Service notifies the participating civic group, which keeps a file on the people enrolled. The group then calls a friend or relative who has agreed to follow up in the event of such a warning sign.

Older postal employees and candidates for employment were benefited during 1978 by the enactment of the Age Discrimination in Employment Act. This statute eliminates previous restrictions that permitted persons over 70 to be hired only for temporary appointments not to exceed 1 year and that required retirement for persons reaching age 70 after 15 years of service. Older postal employees continue to benefit from the Postal Service preventive medical program. Our medical and health units provide advice and counsel concerning such subjects as advancing arthritis, cardio pulmonary conditions, cancer, vascular disease, and respiratory infectioins, in order to encourage proper attention and care for these problems. Also, our personnel offices give "exit interviews" that address medicare and supplemental health programs and offer seminars on retirement.

In conclusion, I would like to stress again this year that senior citizens who suspect they have become targets of mail fraud or false representation are urged to make their complaints known to a responsible employee at a postal installation near them. We are here to help them and their inquiries will receive prompt and conscientious attention. Also, if they are considering the purchase of a product or service by mail, I hope they will investigate the offer before they invest in it.

Sincerely,

William F. Bolger.

Enclosures.

Civil Enforcement Under the False Representation Statute

(1) In *Independent Food Aid Program*, a mail stop order pursuant to 39 U.S.C. § 3005 was obtained against the promoter of a scheme allegedly furnishing Government food stamps to senior citizens at reduced prices.

(2) In *Midwest Health Research*, a mail stop order, preceded by injunctive relief pursuant to 39 U.S.C. § 3007, was issued against the promoter of an alleged "cure-all" method, falsely promising relief to persons suffering from degenerative diseases. The method involved use of a long discredited procedure (colonic irrigation) and the promoter has been convicted of mail fraud (18, U.S.C. § 1341).

(3) We have taken action against a number of "work-at-home' schemes where exaggerated promises of return upon moderate investment and home labor are involved. These schemes are typically pitched to older people who wish to supplement retirement income.

(4) We have also taken action against a variety of cosmetic products falsely advertised to remove wrinkles or allow the user to "look years younger."

(5) In *All Products Unlimited*, we obtained a mail stop order against the promoter of a "magnetic bracelet" allegedy capable of curing arthritis.

(6) In *Breaking Free*, we obtained an agreement whereby the promoter of a diet allegedly capable of curing and preventing cancer agreed to discontinue the promotion.

(7) We have taken action against a wide variety of products allegedly capable of maintaining or prolonging the virility of older mail users.

(8) In *Evero Laboratories*, we obtained an agreement whereby the promoter of a vitamin pill alllegedly capable of curing cataracts without surgery agreed to discontinue the promotion.

(9) In *United Health and Retirement Association*, a mail stop order was obtained against a promotion involving false promises of savings obtainable through a medical insurance plan.

(10) In *Rev. Billy Sunday*, we obtained a mail stop order against a rheumatism and arthritis cure.

(11) We have recently discussed with staff investigators on the House and Senate Committees on Aging and the Federal Trade Commission, possible use of 39 U.S.C. § 3005 against exaggerated coverage and benefit claims in mail order insurance directed primarily to older persons. Our review to date has been inconclusive.

CRIMINAL ENFORCEMENT

1. INSURANCE FRAUDS

Elderly persons are oftentimes unable to resist the high pressure sales tactics of unscrupulous operators, and are not sufficiently discerning to recognize that the product or service they are being sold is grossly misrepresented. Typical of these fraudulent schemes are the following:

Five persons sold worthless vehicle warranty policies to over 60 elderly individuals—some of whom did not own automobiles—who believed that they were purchasing accident and health policies. Four operators of the schemes were convicted and sentenced to a total of 25 years' imprisonment.

Over 70 elderly persons were victimized by two swindlers who sold them worthless vacant lots. The purchasers understood that they were buying paid-up insurance policies. The swindlers were indicted and convicted.

In a separate scheme, five persons—including four of those who sold the worthless lots above—sold duplicate accident and health policies to more than 200 elderly victims who were not aware that they were paying needlessly for insurance duplicating coverage they already had.

2. HOME IMPROVEMENT FRAUDS

Elderly persons are frequently incapable of performing the physical work involved in home maintenance or repair, and become the targets of dishonest mechanics and contractors. Falsely representing, on occasion, that failure to have the work done will result in a hazardous condition or will place the homeowner in violation of a local ordinance, the contractor will charge for work not performed, or done shoddily, frequently requiring the victim to encumber the property to secure funds for payment to the contractor.

The officers of a home improvement company, concentrating on elderly people in rural areas living on fixed incomes, pensions or social security benefits, induced approximately 118 victims to sign contracts for home improvements. In applying for loans to a savings and loan association, the officers of which were in collusion with the contractors, applicants were urged to consolidate their other debts and add them to the cost of the home improvements so as to increase the amount of the loans. The victims' homes were pledged as collateral for the loans. Interest rates and the amount and number of monthly installment payments were misrepresented to the homeowners. Investigation of the scheme culminated in a 109-count mail fraud indictment. The principals in the improvement company and in the savings and loan association who were charged in the indictment ultimately pleaded guilty.

In a similar but unrelated home improvement scheme, which also involved misrepresentation in the financing agreements, the fraudulent operator was convicted in Federal court and sentenced to 5 years' imprisonment.

In still another home improvement scheme, nine persons were convicted of using high pressure tactics and misrepresentations to induce elderly homeowners to sign home improvement contracts, pay cash, and then fraudulently obtained improvement loans in the names of the victims on the basis of the contracts.

A building contractor, who operated a home improvement scheme preying upon elderly, widowed homeowners, was convicted of mail fraud and sentenced in January 1977 to 15 years' imprisonment, to be followed by 5 years' probation. A condition of the probation was restitution of some $37,500 to his victims.

3. WORK-AT-HOME SCHEMES

Many elderly persons have limited incomes and understandably are interested in supplementing them, while at the same time they are unable by reason of infirmity or lack of mobility to take full-time employment or employment away from their homes. They are the natural targets for those who promote fraudulent work-at-home schemes.

Using a spurious publishing company as a cover, three promoters mailed approximately 23,000 letters throughout the United States soliciting applicants to work at home stuffing envelopes. Applicants were required to submit a $15 registration fee with their applications. Those who paid received nothing for their money, and were unable to obtain refunds. Two defendants were convicted in Federal court and received prison sentences.

In a variation of the work-at-home scheme, approximately 160 victims were defrauded by an individual who sold them distributorships to sell by mail from their homes copies of his three books describing his success in the mail-order business. A mail stop order was obtained by the Postal Inspection Service to put an end to this promotion.

Still another variation of the envelope-stuffing promotion required applicants to pay an $8 fee, for which they received instructions on how to start promotions like the one to which they had fallen victim. Again, a mail stop order was used to bring this promotion to an end.

4. REAL ESTATE FRAUDS

Directed at much the same group as the investment frauds are fraudulent realty schemes which victimize the better off among the elderly. Some victims purchase property for retirement or second homes, others as an investment, expecting that appreciation in land values would give them a better return on their money than more conventional land conservative investments.

Some 40 to 50 gulf coast and Florida property owners, many of them elderly, were persuaded to exchange their properties—underevaluated or evaluated as worthless by the operators of this realty scheme—for vouchers to be applied to the purchase price of more expensive properties offered by the promoters. The victims were misled into believing that the promoters would sell their newly acquired properties for them within a few months at a high price, recouping their investments and giving them a profit. In reality, the properties offered by the promoters were overvalued by the amount of the vouchers, so that the victims paid full price for the new properties and received nothing for the properties they exchanged. No effort was made by the operators of the scheme to sell the victims newly acquired properties. The promotion filed in bankruptcy in December 1977 and its principals were indicted for mail fraud in April 1978.

Another scheme involved the sale of approximately $4.3 million in corporate promissory notes supposedly secured by first mortgages on realty. In actuality, the notes were unsecured and worhtless. Six promoters of the scheme were indicted and convicted of 40 counts of mail fraud.

5. INVESTMENT SCHEMES

Not all elderly persons have limited incomes. Many are comfortably retired and have savings accumulated over a lifetime of hard work. Many are widows or widowers who have received substantial proceeds of insurance policies on the deceased spouse. They have a natural interest in investing their money in a manner that will provide the greatest return for themselves or for their children and grandchildren. This group is a target of the more sophisticated fraudulent schemes.

Currently under indictment and awaiting trial is an investment scheme promoter—himself 72 years old—who induced some 30 persons, elderly and mostly widowed, to entrust him with, in one case, as much as $160,000 for investment. Many of the victims were unfamiliar with financial matters and relied completely upon his counseling and his promises of lucrative, guaranteed-secure investments. Some lost their entire life savings. In May 1978, the promoter was indicted by a Federal grand jury on 11 counts of mail fraud.

Over 40 elderly persons were induced to invest more than $485,000 in a real estate brokerage and management company for the purpose of supplementing their retirement incomes with guaranteed monthly payments representing a 12 percent return on their investments. The operator of the scheme had concealed the fact that the company was actually losing money, and had distributed a falsified balance sheet listing assets which the compny did not own. In July 1978, the operator was convicted on 18 counts of violation of the Mail Fraud Statute and 3 counts of perjury. He received prison terms totaling 12 years.

6. MEDICAL FRAUDS

Elderly people, susceptible to the illnesses and infirmities of advancing years, are a target for the fraudulent schemes which offer pills, potions and nostrums of all sorts to cure illnesses, grow hair on bald scalps, restore sexual potency and rejuvenate fading beauty.

A self described doctor, principal in a national health clinic, distributed an estimated 2 million brochures throughout the United States and Canada offering for sale a "Health Bible," promoting a colonic irrigation treatment for the prevention, alleviation and cure of some 40 diseases, including malnutrition, arteriosclerosis, gallstones, diabetes, asthma, arthritis and appendicitis. The book offered a colonic irrigation "kit" for sale for an additional sum. The total number of victims of this scheme is unknown, but it is believed that at least 1,000 victims paid $9.95 for the "Health Bible." Expert medical testimony at the hearing which resulted in issuance of a mail stop order identified the colonic irrigation kit as an ordinary enema and described it as not only of no benefit in the treatment of the disease or conditions for which it was recommended but potentially harmful in certain cases. The operator of the scheme subsequently pleaded guilty to two counts of a 10-count indictment.

7. MISCELLANEOUS

Indicted and awaiting trial are two operators of a fraudulent scheme which targeted the elderly and infirm by inducing them to pay in advance for grave memorials which were never furnished.

THEFT OF MAIL

During the last 10 years, check mailings have steadily increased until there are now more than 800 million Federal, State, and local government checks entered into the mails annually. Check letters are most vulnerable to theft when they reach the public's mail boxes. The problem of mail theft is most severe in the low income areas of the larger cities where millions of welfare and social security checks are delivered each month. The poor and elderly residents of those areas suffer undue hardships when forced to wait for replacement for a stolen check or stolen document authorizing the purchase of food stamps.

The check thief's crime is not completed until a stolen check is converted into cash or merchandise. Consequently, this offense usually leaves a "paper trail" for investigators to follow. Postal Inspectors working with other Federal, State, and local law enforcement officers have developed investigative techniques which have made mail theft an extremely high risk crime. In fiscal year 1978, a total of 12,936 convictions were obtained for the theft of mail or for the related offense of possession of stolen mail. Incidents of mail theft reported to the Inspection Service were down 22 percent from the previous year and are currently at the lowest level in 10 years.

In addition to relying on the apprehension and prosecution of offenders to deter mail thefts, the Inspection Service, in the past year, initiated a test program aimed at involving citizens in assisting in the prevention of crime. The program, known as curb area thefts (CAT), was initially limited to selected cities in the eastern United States. Direct communication was established with postal customers who were asked to report anyone observed committing a violation of the postal laws. The program was publicized in newspapers, on radio and television, and through the display of posters in public places. The objectives of the program were explained in presentations to civic groups, church congregations, students, and local merchants.

It is too early to fully evaluate the impact of the program in reducing thefts, but the early response from the public has been encouraging and the Chief Postal Inspector has expanded the test to include one city in each of the midwest, Southern, and Western areas of the country.

ITEM 28. RAILROAD RETIREMENT BOARD

JANUARY 9, 1979.

DEAR MR. CHAIRMAN: In response to your letter of December 1, 1978, I am pleased to enclose a statement summarizing major activities of the U.S. Railroad Retirement Board on aging during 1978. I have also described some of the Board's plans and goals for 1979.

We look forward to your committee's 1978 report on developments in aging.
Sincerely yours,

R. F. BUTLER,
Secretary for the Board.

Enclosure.

U.S. RAILROAD RETIREMENT BOARD

The U.S. Railroad Retirement Board is the Federal agency that administers a comprehensive social insurance and staff retirement system for railroad workers and their families, separate from but coordinated in several ways with social security. Programs of the system include the following: (1) Old-age, survivor and disability benefits under the Railroad Retirement Act; and (2) unemployment and sickness insurance benefits under the Railroad Unemployment Insurance Act. In addition, certain administrative services under the Federal health insurance (medicare) program are performed with respect to aged and disabled railroad workers and eligible members of their families.

BENEFITS AND BENEFICIARIES

During fiscal year 1978, benefit payments under the railroad retirement and railroad unemployment insurance programs totaled $4.2 billion, an increase of $219 million from the same period 1 year earlier. Retirement and survivor benefit payments amounted to $4 billion, an increase of $201 million over the same period 1 year earlier. Unemployment and sickness benefit payments during the benefit year ending June 30, 1978, totaled $184 million, which was $5.6 million less than in the preceding benefit year.

The number of beneficiaries on the retirement-survivor rolls on September 30, 1978, totaled 1,019,000. The vast majority (81 percent) were aged 65 and older. At the end of the fiscal year, 460,000 retired employees were being paid a regular annuity averaging $409, about $29 higher than a year earlier. In addition, 176,000 of these employees were being paid a supplemental annuity averaging $55.

Over 232,000 spouses of retired employees were receiving an average annuity of $191. Of the 335,000 survivors on the rolls as of September 30, 1978, 292,000 were aged widows receiving an average annuity of $285. Some 868,000 individuals who were receiving or were eligible to receive monthly benefits under the Railroad Retirement Act were covered by hospital insurance under the medicare program at the end of fiscal year 1978. Of these, 847,000 (98 percent) were also enrolled for supplemental medical insurance.

Unemployment and sickness benefits under the Railroad Unemployment Insurance Act were paid to 164,000 railroad employes during the benefit year ending June 30, 1978. However, only about $1.1 million (less than 1 percent) of the benefits went to individuals aged 65 and older.

LEGISLATIVE DEVELOPMENTS

While there were no amendments to either the Railroad Retirement Act or the Railroad Unemployment Insurance Act, Board programs were affected by amendments to the Social Security Act in fiscal year 1978. Because of laws coordinating the railroad retirement and social security systems, certain provisions of Public Law 95-216, amending the Social Security Act, also apply to the railroad retirement system. Some of the major changes affecting the railroad retirement system include revisions in the method of computing benefits, retirement tax increases and reductions in the benefits of spouses, widows and widowers who also receive public pensions. The amendments also allow higher post-retirement earnings before benefits are reduced and further increase the benefits of those who postpone retirement beyond age 65.

PLANNED ACTIVITIES

At the request of railroad management and labor, the Board will provide technical assistance in legislative recommendations to correct the financial problems of the railroad retirement system. While the Railroad Retirement Act of 1974 substantially improved the system's financial condition, an actuarial deficit and cash flow problem still remain.

The Board is committed to an improvement in its service to the railroad public. Over the past few years, extensive legislative changes have made the Board's programs much more complex and difficult to administer. With initial implementation to this legislation accomplished, the Board has begun extensive evaluations of operations, procedures and facilities to identify areas where improvements in service can be made.

Quality control programs, designed to measure and monitor error rates, identify causes of erroneous payments, and reduce or eliminate errors, are in the process of development for both the retirement-survivor and unemployment-sickness benefit programs.

Since many railroad employees retire without adequate counseling or preparation, the Board is investigating the feasibility of preretirement counseling. Such counseling would be designed to examine the advantages and disadvantages of retrement on an individual basis and help railroaders to better understand and prepare for retirement.

ITEM 29. SMALL BUSINESS ADMINISTRATION

DECEMBER 27, 1978.

DEAR MR. CHAIRMAN: This is in response to your letter of December 1, 1978, concerning programs relating to aging.

In 1964, the Small Business Administration established a volunteer program called the Service Corps of Retired Executives (SCORE). The program has continued to expand and there are now some 8,200 members of SCORE. The objective of this program is to provide management assistance service to the small business community. The Active Corps of Executives (ACE), is comprised of business people who have not retired.

SCORE is comprised of volunteers retired from the active business world who have had a lifetime of business experience and are willing to share this knowledge and experience with others. SCORE provides a businessperson-to-businessperson advisory, relationship. In addition to the invaluable service that is derived by the small business owner/operator, there is an added benefit to the volunteers. SCORE members know that their aid is needed and their participation provides the retired volunteers with a sense of satisfaction for contributing his or her knowledge to help others.

SCORE volunteers have counseled over 500,000 small businesses since 1964 and the organization has grown from the initial 1,000 members to its current membership level organized into 342 chapters located throughout the United States. In fiscal year 1978, SCORE volunteers counseled over 139,000 small business owner/operators.

Sincerely,

A. VERNON WEAVER, *Administrator*.

ITEM 30. VETERANS ADMINISTRATION

FEBRUARY 5, 1979.

DEAR MR. CHAIRMAN: In response to your request of December 1, 1978, I am pleased to forward the enclosed report on the Veterans Administration activities relating to the developments in the care of older veterans for the year 1978.

The VA is well aware of its responsibilities to the aging veteran and the problems that will result from the increasing number who will seek VA assistance. Plans and programs have been developed over a considerable period of time and are being emphasized to meet these needs as they become increasingly pressing during the remainder of the century. The VA believes that these plans are comprehensive, but flexible enough to meet changing needs as knowledge and technology develop.

I hope the enclosed information will be helpful to the committee. Please let us know if we can be of further assistance.

Sincerely,

MAX CLELAND, *Administrator*.

Enclosure.

VA ACTIVITIES AFFECTING OLDER AMERICANS IN 1978

1. INTRODUCTION

The historic pattern of American wars has created increased numbers of veterans at roughly generational intervals. As a result, there is a concentration of veterans who will pass through various ages together as they grow older.

Most of the World War I veterans were aged 65 to 75 between 1960 and 1970; aged 75 to 85 between 1970 and 1980; and the survivors over age 85 will be most numerous between 1980 and 1990. The World War II-Korean War veterans will have similar age concentrations between 1985 and 1995, 1995 and 2005, and 2005 and 2015, respectively. Since this is a uniquely large group, and the needs of the aged change during these three periods, projections for health service delivery and other benefits require a recognition of these variables.

In January 1978, the Veterans Administration submited a comprehensive report to the appropriate committees on veterans affairs of the Senate and House of Representatives. Entitled "The Aging Veteran: Present and Future Needs," this report outlined long range plans for meeting the needs of this aging veteran population.

On a more immediate basis, a wide variety of services were provided for aging veterans during the past year and are described in the following paragraphs.

2. EXTENDED CARE

The rapidly expanding veteran population above the age of 60 requires increased attention to patient care programs which provide both alternatives to costly hospital care for patients requiring long-term institutional care and alternatives to institutional care itself. The Office of the Assistant Chief Medical Director for Extended Care, accordingly, organizes the patient care programs for which it is responsible along a continuum of care, ranging from skilled nursing home care to programs designed to maintain independent living in the community. Because its programs cut across many other central office functions, some staff activities of this office are referred to in other sections of the report.

The patient care mission of this office is to provide the necessary professional expertise and leadership for the following long-term care programs: VA nursing home care, community nursing home care, personal care homes, hospital based home care, domiciliary care, State home care (nursing home, domiciliary, and hospital). In order to improve the care of older veterans through the development of new programs targeted toward the elderly, it also administers eight geriatric research, education, and clinical centers.

Large numbers of aged veterans requiring long-term care will place an ever increasing demand on the clinical programs. A major concern of this office is the assessment of various approaches to long-term care programs to assure that the VA health care system is available and responsive to those veterans in need of such care. Through increased emphasis upon coordinating a variety of long-term care programs, it is expected that the VA will improve the quality of care for patients of all ages, broaden the comprehensiveness of our services, increase patient satisfaction, and, in a time of rapidly increasing cost for health care services, make more effective use of manpower and resources.

VA Nursing Home Care

This program is designed for veterans who are not acutely ill or in need of hospital care, but who require skilled nursing care and related medical services. The services are prescribed by, or performed under, the general direction of persons duly licensed to provide such care. Typically, a veteran admitted to VA nursing home care is chronically ill, has a permanent or residual disability, is expected to require a long period of nursing supervision, observation and care, and requires special efforts of a long-term rehabilitative nature. All the services required for the comprehensive care of a veteran in the nursing care unit are available through the resources of the hospital. Nursing home care beds were increased during the course of the year with the opening of new nursing home care units at Loma Linda, Calif.; Phoenix, Ariz.; and Wilmington, Del. During 1978, there were nursing home care units at 91 VA medical centers with 7,935 average operating beds with an average daily census of 7,480. The number of patients treated was 11,671.

Community Nursing Home Care

This program is designed for veterans who are not acutely ill and not in need of hospital care, but who require skilled or intermediate nursing home care and related health care services. The primary purpose of this program is to aid the veteran and his family in making the transition from a hospital to the community by providing time to marshal resources for the veterans' continuing care. Participating facilities are assessed by VA personnel prior to approval and no less than every 2 years thereafter. Followup visits are provided to the veteran in the nursing home by the hospital social worker, nurse and other members of the treatment team. Under this program, nonservice-connected veterans may be placed in community facilities at VA expense for a period not to exceed 6 months. Veterans requiring nursing home care for a service-connected condition may be placed at VA expense indefinitely.

As of September 30, 1978, 2,459 nursing homes were under contract with the agency, 1,245 of which were skilled homes and 1,214 of which were intermediate care facilities or combined skilled and intermediate care facilities. A total of 26,996 veterans were served by this program during fiscal year 1978 with an average daily census of 7,997.

During the past year, the VA has continued to develop an approach to nursing home assessment which emphasizes the quality of care and quality of life in the home. Parallel to this effort, the VA has continued to work more closely with other Federal and State agencies in order to coordinate and avoid duplication of effort in the assessment of nursing homes. These closely related endeavors have been pursued through a series of regional conferences for VA community nursing home teams and through administrative meetings with VA, HEW, and State survey agency staff.

Hospital-Based Home Care

This program allows for an early discharge of veterans with chronic illness to their own homes and reduces readmissions to the hospital. The family provides the necessary personal care under coordinated supervision of a hospital-based multidisciplinary treatment team. The team provides the medical, nursing, social, rehabilitation, and dietetic regimens as well as the training of family members and the patient. Thirty VA hospitals are providing hospital-based home care services. By providing increased days of care in the home, acute care beds in hospitals are freed up. An educational training experience was provided selected team members in program evaluation and patient care audits through the Minneapolis Regional Medical Education Center (RMEC). This training experience was designed to assist HBHC teams to develop a quality assurance program. On-going training conferences are being planned for anticipated program expansion.

VA Domiciliary Care

The VA domiciliary program is designed to provide necessary medical treatment and comprehensive professional care for eligible ambulatory veterans in a residential type setting. The program is directed toward those veterans who are disabled by age, disease, or injury and are in need of care, but do not require hospitalization or the skilled nursing services of a nursing home. To be entitled to domiciliary care, the veteran's disability must be chronic in nature. The veteran must also be incapacitated from earning a living and have no adequate means of support.

A modest construction effort has been initiated to improve existing domiciliaries which recognizes the need for emphasis on privacy and on the psychosocial needs of older veterans in congregate living. The design criteria that have been developed provide an environment that is free of architectural barriers and encourage physically disabled veterans to function at their optimal potential. The new 20-bed domiciliary being constructed at the Wood VA Medical Center in Milwaukee, Wis., is nearing completion and others are scheduled in the near future.

In fiscal year 1978, the 16 domiciliaries operated 9,751 (average) beds with an average daily census of 8,721. The number of patients treated was 17,275.

Personal Care Homes

This program provides personal care and supervision in a homelike setting in the community for veterans who have no homes or whose home does not provide the care they need. The veteran pays for his care, usually out of the combination of VA pension, supplemental security income, and/or social security disability payments. All veterans with sufficient funds may utilize this service. Homes vary in size from those accommodating one veteran in a family setting to homes accommodating 20 or more veterans. Homes are periodically inspected by an interdisciplinary team from the nearest VA hospital. Regular followup visits to the homes are made by members of the VA hospital staff. The social worker is the most frequent visitor, working with relationships between sponsor and veteran, veteran and family, and veteran and the community.

During fiscal year 1978, the General Accounting Office completed a study of the program. While noting the need for greater administrative efficiency and for clearer guidelines for the program, the report strongly recommended the expansion of the program as a cost effective alternative to hospitalization.

In December 1978, the VA completed a survey of a systemwide sample of veterans currently in the program and of now institutionalized, potential candidates for placement into the program. The data retrieved are undergoing analyses and are expected to be of great value in planning for the expansion of the program to meet the needs of veterans who would be appropriately placed at this level of care.

State Home Program

The State home program has grown from 11 homes in 11 States in 1888 to 40 State homes (one of which has two annexes) in 31 States including the District of Columbia. Currently a total of 15,815 beds are available to provide hospital, nursing home and domiciliary care. The VA relationship to State veterans' homes is based upon two grant programs. One is a per diem program which enables the VA to assist the States to provide care that meets modern standards of quality to veterans requiring domiciliary, nursing home, and acute and intermediate hospital care. The other grant program provides VA assistance with 65 percent Federal funding in the construction of new domiciliary and nursing home care facilities, and the expension and remodeling of existing facilities. The State home per diem program is administered through VA medical facilities which reimburse the States on a quarterly basis. The construction program is administered by central office.

Since the enactment of Public Law 88-450 in 1964, VA grants have been utilized by 22 States for construction projects for nursing home beds. Public Law 91-178 made it possible for the VA to participate in the remodeling of existing hospital and domiciliary facilities. The provisions of Public Law 95-62 enabled the VA to continue to assist the States with new construction funding, and expanded the construction program to include domiciliary facilities within an authorized appropriation.

In 1978, new construction resulted in the addition of a 360-bed nursing home care unit (NHCU) at Marshalltown, Iowa; a 50-bed NHCU addition at Tilton, N.H.; and a 50-bed NHCU at Bristol, R.I. An existing facility in Hastings, Minn., was recognized by the VA as a 150-bed annex to the State veterans' home at Minneapolis, Minn. In addition, the VA obligated funds in fiscal year 1978 totaling over $10.6 million in support of constructing an additional 455 NHCU and 263 domiciliary beds.

During fiscal year 1978, the average daily census in State veterans' homes was 4,945 NHC, 5,236 domiciliary, and 1,004 hospital patients.

Geriatric Research, Education and Clinical Centers (GRECC's)

Geriatric research, education and clinical centers are charged with the task of advancing clinical, research and educational achievements in the area of geriatrics and gerontology, and integrating these into the total VA health care system.

During fiscal year 1978 another GRECC was initiated at the VA Medical Center in Minneapolis, Minn. This became the eighth GRECC in the VA system, with others located at American Lake/Seattle, Wash.; Boston/Bedford, Mass.; Little Rock, Ark.; St. Louis, Mo.; Palo Alto, Calif.; Sepulveda, Calif.; and Los Angeles (Wadsworth), Calif.

Selected specific accomplishments of these centers during the past year are:

A memory clinic was established at the Boston OPC GRECC. This involves an examination of modes of clinical diagnosis and the design of methods of intervention in memory changes with aging.

The GRECC located at the VA Medical Center, Little Rock, Ark., completed remodeling and staffing, and activated its 28-bed geriatric rehabilitation unit. In addition, the geriatric ambulatory clinic was moved to new, enlarged facilities, enabling an increase in the number of patients seen.

The GRECC at the VA Medical Center Wadsworth, (Los Angeles), Calif., activated a 15-bed geriatic clinical evaluation and demonstration unit.

The Office of Academic Affairs initiated a fellowship program in an effort to prepare board eligible physicians in internal medicine, family practice, and psychiatry for clinical excellence in geriatrics an gerontoolgy. Of the six program awards made, four are at VA medical centers which have GRECC's (Bedford, Little Rock, Palo Alto, and Wadsworth). An additional six sites will be selected during fiscal year 1979 and the remaining GRECC's are under consideration for awards.

Information and Referral Program

To minimize duplication of effort and to promote efficient use of resources, the VA is actively participating in coordinative endeavors with other Federal agencies on behalf of elderly veterans to provide information and referral services.

During the past year, the VA has participated in the following activities:

Information and Referral liaison representatives from VA medical centers and regional offices have contacted the area agencies on aging (AAA's) within their various jurisdictions to offer the services of the Veterans Administration. Service to the AAA's is being provided in varying degrees depending upon the responses to the initial VA contact. Many AAA's are visited regularly, others are visited on an on-call basis. In some areas, personnel from the Department of Veterans Benefits have conducted veterans benefits training seminars for AAA's intake counselors.

Activity continues in the area of introducing veterans discharged from VA medical centers to senior citizen centers in their local communities. Volunteers are being used to assist in these programs. Veterans Service personnel are establishing liaison with many of these senior citizen centers to assist in matters relating to veterans benefits.

In one State, VA Department of Medicine and Surgery (DM&S) social workers and Department of Veterans Benefits (DVB) Veterans Service personnel have initiated regularly scheduled visits to residence hotels where large numbers of veteran single room occupants live in order to offer information and assistance about VA medial programs and benefits.

Over 200 VA employees participated in training conferences for I&R liaison representatives from both DM&S and DVB located in HEW regions I through X at Salem, Va.; St. Louis, Mo.; Birmingham, Ala.; Northport, N.Y.; Minneapolis, Minn.; and Long Beach, Calif. These conferences gave an overview of I&R development, operation of agencies and resources required for ongoing provision of services. Technical experts from I&R agencies and administrators from Federal, State, and local agencies on aging, and Alliance of Information and Referral Services personnel were part of the faculty.

Each year, approximately 8,500 veterans are placed in community nursing homes from VA medical centers. Veterans Service personnel are conducting benefits awareness campaigns at many nursing homes to alert administrators and staff at these homes to the availability of VA benefits for veterans and widows.

The VA has been involved in many State, county, and local activities for the elderly, such as: Federal executive board, senior citizen showcase of benefits, and a Governor's conference on aging.

Efforts to stimulate interest in VA benefits and medical programs among potential elderly beneficiaries have included establishing rapport with local newsletters, newspapers and other publications circulated among the elderly. Press releases are prepared concerning benefits and services for this target population, and distributed to publishers. Responses have been favorable.

A brochure "Information and Referrals for Veterans 60 years or Older" has been prepared listing services available from VA and community agencies for seniors. The list was completed in large print, making it easy to read. This AoA-VA joint activities project was presented at the VA I&R conference for adoption systemwide.

MEDICAL SERVICE

The Veterans Administration Central Office Medical Service and the Medical Services in Veterans Administration medical centers pursued their goal of improving the overall quality of medical care provided veterans during 1978 with vigor. Once again a large share of their efforts were devoted to the aging veteran group since these patients constitute a significant portion of our patient population both in terms of numbers and professional challenges.

In addition to this general medical interest in the aged patient, several more specific activities in ths area were carried out during 1978 and should be cited. The Veterans Administration's study of extended hospital care (EHC), mentioned in last year's report, was expanded and completed during the year. Medical Service played a key role in this extensive multidisciplinary evaluation of the current and future needs of, and programs for, long-term patients in the VA. Comprehensive recommendations for the development of optimal EHC programs will be presented to the Chief Medical Director in early 1979. The newly established centers for handling rheumatology-immunology and cardiopulmonary rehabilitation problems continued their growth and development in 1978 with obvious impact on the care of the aging veteran. Medical Service continues to play a significant role in the evaluation of these centers and will do so in the future. Medical Service is also collaborating with Dietetic Service to initiate a comprehensive clinical nutrition program throughout the entire agency. The potential significance of improved nutrition for aging patients in promoting better quality of life and quality of care is great. Medical Service representatives participate actively in various professional conferences and meetings on aging (e.g., "Initiating Strategies for VA Geriatric-Gerontology Programming," a VA sponsored meeting held in Dallas, Tex., in November 1978).

Medical Service plans to continue and expand its role in this very important area of internal medicine in 1979, and the future.

4. MENTAL HEALTH AND BEHAVIORAL SCIENCES SERVICE

The Mental Health and Behavioral Sciences Service has increased its efforts and activities directed towards the older psychiatric patients. With increasing age there is increasing incidence of mental problems, and the number of older veterans being treated in our psychiatric medical centers will continue to increase into the next century.

One major development was a meeting held October 23-25, 1978, with the chiefs of psychiatry and psychology from 40 VA medical centers with the largest number of psychiatric patients. This training conference focused specifically on the psychogeriatric patients. The faculty for this meeting was composed of professional ward staff from three VA medical centers which have established ongoing psychogeriatric special treatment wards/units. Emphasis was given to development of specialized skills required to properly treat and rehabilitate the elderly veteran. These involved consideration of physical health, social situation, economic resources, self-help and transportation needs, as well as treatment of the patient's functional disorders. Different models were presented to allow the participants to develop their individual programs to better care for their aged psychiatric patients.

During the year three program guides were developed, one of which has already been published, on the appropriate use of psychiatric medications. In each of these guides special emphasis is given to the problems relating to the elderly patients, as well as the problems of drug selection and dosage levels. This is especially important since, with advanced age, the patient's ability to distribute, bind, detoxify and eliminate such drugs is often reduced.

One VA medical center has established the first VA psychogeriatric day center. The center is called the "Elder Veterans Service Center" and is presently functioning to assist aged veterans to secure maximum levels of physical independence, social system development, and the appropriate use of community resources. The Elder Veterans Service Center was implemented to serve patients from the Psychiatric Service, Intermediate Care Service, and the Nursing Home Care Unit at the Palo Alto VA Medical Center, Menlo Park Division. The center is currently under the leadership of a doctoral level clinical psychologist and may serve as a prototype for additional centers in the VA health care system.

A fourth new thrust has been the work of the Mental Health and Behavioral Sciences Service working in concert with other professional services to develop a "quality of life report" which was specifically directed towards aging veterans. The report was sent to all of our medical centers. It defined the quality of life concept, delineated areas of concern within the definition, devised specific items and field tested and revised a series of evaluative instruments. Copies of this report are available from the Mental Health and Behavioral Sciences Service (116B). This is one of the first efforts of a major health care system to evaluate and assure enhancement of living as well as to maintain life for the aged.

5. SOCIAL WORK SERVICE

The development and coordination of community support services for the mentally and physically handicapped elderly was given impetus during 1978 by the participation of Central Office Social Work Service on the White House Committee on Services to the Handicapped. Through a subcommittee on independent living, the Veterans Administration's 30 year experience in the development and operation of community support programs, including the residential component, was highlighted and issues were raised concerning the need for cooperation in the development of a Federal interagency thrust in community support service programming. A key recommendation is that the Veterans Administration participate in a federal interagency demonstration project focused on "independent living" for the handicapped.

As the cost of acute medical care continues to escalate, there is every indication that alternatives to institutionalization meeting quality of care and quality of life standards will be more fully utilized by the VA and other agencies to meet the needs of the elderly, particularly those with emotional or physical handicaps. During fiscal year 1978 over 66,000 veterans received placement and followup services in VA approved community facilities. Over 3,600 veterans were placed directly in community settings without a period of VA hospital care. The development of quality of life and quality of care indicators for veterans placed in community settings was highlighted at several workshops held under the auspices of the Office of Extended Care during fiscal year 1978. In using a multidisciplinary focus, social workers, nurses and dietitians examined traditional roles in the assessment of community settings and in the delivery of services. Emphasis was placed on the need to prevent unnecessary duplication of services and to focus on a more effective use of available manpower in the assessment of community facilities.

An innovative outreach program is developing in a number of medical centers whereby veterans living alone in personal care homes are encouraged to participate in activities provided under the auspices of senior citizen centers, veterans service organizations or other community groups. These social and recreational activities support the re-entry of the veteran in community life following hospital care, and help to prevent the gradual and premature loss of social functioning which sometimes occurs among the elderly who have lost the sense of security which comes with close interpersonal relationships. A goal is to assist the elderly in maintaining as independent a life style as possible. The reestablishment of productive social patterns which may have been dormant for years encourages the elderly to reassert control over their own lives through active participation in the decisionmaking process. An example involves services to veterans in an inner city hotel, most of whom are elderly. The manager of the hotel requested assistance from the VA and a community agency to assist veterans and other residents in establishing contact with appropriate community services. Initially, social workers from both agencies met informally with the residents over coffee and donuts. Gradually the residents began to develop their own list of priorities which included improvements in the physical plant and services provided by the hotel. The experience demonstrated that older people can bring their collective influence to bear on the resolution of problems affecting their future. In effect, they can become advocates for their own needs which reduces the need for a direct involvement of social work and other staff in the resolution of problems.

Social work liaison staff have been appointed in eight medical districts in order to facilitate the development of community support services for an aging veteran population incapable of fully independent functioning. Key social workers in Medical Districts V through XII will assist central office Social Work Service in determining priorities and in developing strategies for meeting the needs of this veteran population. If proved successful, this project will be expanded to other medical districts.

Considerable interest has been generated in the need to develop day care center activities for the elderly living in the community. At least one medical center has developed an activity center which incorporates classes in retirement planning, financial management, information and referral services, and brief counseling services which will be offered to older veterans and their families. Assistance is also available to veterans in maintaining suitable living arrangements or in locating supportive care situations. During fiscal year 1979 there will be continuing emphasis on the need to develop and extend services to the elderly to enhance the quality of life in support of medical care goals. Social workers will be encouraged to work closely with Federal and State agencies which are also concerned with developing quality programs within budgetary constraints. Emphasis will be placed on the need to develop additional community residence programs in medical centers with a general medical and surgical orientation.

6. REHABILITATION MEDICINE SERVICE

With the majority of our VA patient population over 60 years of age, Rehabilitation Medicine Service has concentrated a major emphasis on programs designed for the aging. Rehabilitation Medicine Service therapists and physicians have been encouraged to engage in continuing education programs designed to stimulate, motivate and provide new programmatic ideas in geriatric care. Two VACO-Rehabilitation Medicine Service sponsored workshops concerned with aspects of aging were presented in fiscal year 1978. While overall Rehabilitaiton Medicine Service programs are geared for most disabilities, new efforts are being made toward modification, adaptation, and, even more importantly, greater sensitivity to the needs of the aging.

Rehabilitation Medicine is currently involved in such programs as sensory integrative dysfunctioning programs to help patients regain the use of their sensory mechanisms or to compensate for their loss; compensated work therapy to provide for monetary incentives in community work projects for a greater feeling of self worth and meaningful activity; cardiac rehabilitation programs designed to treat patients with special diseases—especially important to the geriatric patient; and blind rehabilitation which is concerned with blindness developed by the aging veteran who has special needs not normally found in the younger blinded veteran.

It has been clearly established that the incidence of speech, hearing, and language disorders rises markedly with aging. It is highly important that treatment services be made available to the elderly who are in need of communicative rehabilitation.

Services for communicative disorders are provided at 89 of our medical centers. To cope with the rising workload, a new unit was activated at the Loma Linda VAMC, Calif., in fiscal year 1978, while another is planned for the Augusta VAMC, Ga., in the current fiscal year.

With greater emphasis on gerontology in the VA and a greater divergence of programs concentrated in this area, both greater numbers and varieties of Rehabilitation Medicine Service programs will continually be designed to meet these needs.

7. NURSING SERVICE

Nursing Service has collaborated with three regional medical education centers (RMEC's) in educational endeavors to improve the understanding and knowledge of nurses concerning aging. Conferences and workshops have been held, with VACO staff member participation, at the Southcentral, Southeastern, and Northeastern RMEC's.

In April 1978, Nursing Service published a new program guide, "Standards and Educational Guidelines for Gerontologic Nursing Practice," G-14, M-2, part V. Two chapters comprise the guide. Chapter I covers the standards of gerontologic nursing care. Using Maslow's hierarchy of needs as an organizing focus, nine standards are enunciated. These standards attempt to address the special needs of the elderly along a continuum ranging from psychobiologic needs to those for self actualization and creativity. While the standards are written primarily for use by nursing personnel, they may have value to other health team members should they wish to adapt them for use in their disciplines. It is the intent that the central focus should be the needs of the aged individual rather than any health discipline or occupational group. Chapter II consists of a course outline for gerontologic education for nurses. As with the standards, other health professions may find the outline helpful as a systematic guide to learning more about the special and unique aspects of the normal aging process. Throughout the guide an attempt is made to stress a humanistic, concerned approach to the elderly veteran patient. The need for an enabling environment is addressed throughout the guide, hopefully it will be of assistance to those who seek to improve both the quality of care and the quality of life of the aged, ill veteran. A workshop to design strategies to implement the standards systemwide is planned for June 1979 at the North Central RMEC, Minneapolis, Minn. Three registered nurses from each RMEC area will comprise those invited to design and implement the strategies throughout the system.

VA Nursing Service continues to work closely on matters of mutual concern on aging with the Department of Health, Education, and Welfare, Division of Long Term Care. The staff member responsible for long term care initiatives has served in a consultative capacity in the developing and testing of PACE, the guide to patient care mangement in long term care facilities.

Nursing Service continues to stress the need for more information relating to geriatric and gerontologic nursing. University nursing faculty and VA medical center staff are working collaboratively toward increasing the knowledge base of geriatric nursing practice at the Northport, N.Y.; Durham, N.C.; and Madison, Wis., VA Medical Centers.

The need for improved services to the aged veteran in the community is recognized as a matter of priority by Nursing Service. Several proposals pertaining to this topic have been developed.

8. DIETETIC SERVICE

Nutritional care continues to be an important component of the total treatment program for the aged veteran. Nutritional assessment of veteran patients indicates that disease and disability still contribute significantly to their nutritional risk. One of the risk factors which has a subsequent impact on nutritional status and which should be given more emphasis is the oral health care of the aged veteran patient.

The oral health status of a patient is an important clue to his general health status because the cells and tissues of the lips, tongue, periodontium and teeth are extremely sensitive to functional and anatomic changes produced by nutritional as well as other metabolic aberrations. If the nutritional component is recognized, appreciated and dealt with in the same substantive, objective manner as is done in the nutritional management of such general health problems as heart disease, diabetes and alcoholism, the diagnosis and mangement of oral health problems will be improved considerably. Through coordination with dentistry, a good dental care program for veterans can be implemented as part of an in-depth nutritional care plan.

Patient health education efforts have focused on individual patient diet counseling as well as training of the caregiver in meeting the individual's nutritional needs. Future emphasis will be focused on continuing education programs directed to improving the knowledge and skills of dietitians in working with the elderly, and the use of community resources. The regional medical education centers (RMEC's) have provided educational workshops on nutritional assessment for dietitians. These workshops have implied the need for the development of nutritional quality care standards for the geriatric patient.

In cooperation with the geriatric research, education and clinical centers (GRECC's), Dietetic Service plans to identify through research studies the nutritional risk factors which impact the qualty of care for the elderly.

9. VOLUNTARY SERVICE

During fiscal year 1978 a systemwide survey of medical facilities, culminating in the Administrator's volunteer development report, showed that 65.8 percent of the volunteers are above the age of 60. The report demonstrates that the VA Voluntary Service program continues to provide welcome opportunities for older Americans to participate effectively in the mainstream of community life.

The volunteer development report concludes that older Americans "are the best resource—and the backbone—of the VA Voluntary Service program," and points out that from VA experience, "Older Americans are one of this country's richest, wisest and most committed resources—a gold mine of compassion and experience."

Voluntary Service continued to encourage participation in the evolution of projects for aging veterans initiated by two of its member organizations: "Operation Post Home," sponsored by the American Legion, and the "Haven" project of the United Voluntary Services.

"Operation Post Home" was adopted formally in 1978 as a program of the American Legion and auxiliary to open post homes to the elderly, of the community, especially veterans, for regularly scheduled recreational, educational, and social activities. Successful post home programs were established, with the cooperation of VA Voluntary Service staff, in Duluth and Minneapolis, Minn., and in Central Illinois. Twelve State-level American Legion organizations have expressed strong interest in participating in the program, and the Legion and auxiliary have set as their 1979 goal the participation of posts in 25 of the 50 American Legion departments, again with organizing assistance from the VA.

In the Duluth program, which has been the pilot project, a recreation therapist from the Minneapolis VA Medical Center travels to the post home periodically, a dietitian has given talks, and a telephone contact program has been established. A group of some 25 older veterans meets 1 day weekly, during which the American Legion serves a meal.

The United Voluntary Service "Haven" project, based on the successful leisure time lounge operated by the organization for patients at the Palo Alto VA Medical Center, is popular with elderly veterans, though not limited to their participation. During 1978, with Voluntary Service cooperation, "Havens" were opened at VA medical facilities at Hines, Ill., and Wood, Wis. As the fiscal year ended, 12 other facilities had entered the planning stage for "Havens," and 37 displayed significant interest in working with the United Voluntary Service in the project. Fifteen medical facilities had previously established programs similar to the "Havens."

A Patient Services project designed to study needs for more leisure time activities for long-term care patients, many of whom are elderly veterans, resulted in a restructuring which will provide more emphasis on recreation activities during nontreatment periods.

10. DENTISTRY

The VA Dental Service has continued to strengthen its program to meet the oral health care needs of long term and geriatric patients. VA sponsored conferences on Geriatric Dentistry were held in Dayton, Ohio, and Seattle, Wash. More than 100 dentists participated in these training activities. Meeting the oral health care needs of geriatric patients was also given emphasis on the agenda of seven different administrative conferences that included chiefs of Dental Service from twelve medical districts. Two issues of Dentistry Information Letters carried items emphasizing comprehensive dental care for long-term patients, many of whom are in the geriatric age group. This effort is in accord with the findings and recommendation of the National Academy of Sciences.

Other accomplishments worthy of note are the participation of the Assistant Chief Medical Director for Dentistry in a VA sponsored geriatrics/gerontology meeting and the publication of a textbook, "Geriatric Dentistry: Clinical Applications of Selected Biomedical and Psychosocial Topics," Heath Company, Boston, Mass. The text is a collaborative venture between the VA and the Harvard School of Dental Medicine. It is the only book devoted to the subject of dental care for the geriatric patient.

To effectively deal with one of the problems encountered in the aging process, the VA Oral Disease Research Laboratory, Houston, Tex., has developed a saliva substitute known as Oralube. The product is used throughout VA medical centers for those patients who have reduced salivary secretions and experience great difficulty in swallowing.

The VA is pursuing a vigorous program of preventive dentistry to be implemented in gradual increments in the coming years. Initial programs are in effect at more than 90 percent of VA medical centers. The long range effect of the program will be seen in improved oral health and reduced human suffering especially for the patient in the declining years of life.

The employment of 76 additional auxiliary dental personnel during fiscal year 1978 represents progress in VA capability to deliver dental services. Geriatric patients throughout the health care system are receiving some of the benefits of this additional personnel support.

The Service's overall effort to meet the growing need for dental care in geriatric patients is documented in its current program of management by objectives. The plans include a series of scheduled training programs through calendar year 1981, and the encouragement of investigators in the pursuit of research attuned to the geriatric patient.

11. MEDICAL RESEARCH SERVICE

There has been a gradual increase in the number of elderly persons within the United States over the past several decades. With increasing population age, there has been an attendant increase in the chronic multiple disorders which affect older individuals and the problems of geriatric medical care have become a major concern of our health system. These problems include definition, availability of resources, recruitment and training of professional staff at all levels. In the Veterans Administration the challenge of geriatric care is particularly acute. The single largest group of VA patients is constituted by veterans of World War II, with a median age of 59 years. These individuals comprise three-quarters of the VA inpatient population nationwide, and even larger percentage of patients in the long term and chronic hospitals.

There has been limited recognition of geriatrics within schools of medicine and nursing until recent years. Over the past 5 to 6 years, however, there have developed major advances in recognition of the altered physiology, pathology and response to therapy which are characteristic of geriatrics. These advances have been pioneered by the Veterans Administration, and most significantly through the efforts of the VA Research Service. A brief review of selected current geriatric research activities within the VA follows.

Research in Mechanisms of the Aging Process

At the VA Medical Center in Bedford, Mass., biochemical studies have been made on cell protein synthesis during aging. These studies have shown that cytoplasmic ribosomes do not develop significant errors in protein synthesis despite experimental provocation. This study casts doubt on theories of aging based on cellular metabolic error accumulation.

Investigators at the VA Medical Center Wadsworth (Los Angeles) have continued studies on the immunological aspects of the aging process. Currently, human epidemiological studies are being carried out with veteran patients. A particularly interesting feature of this study is the involvement of aging veteran twins. These studies are designed to define the roles of cell-mediated and humeral immunological factors in vulnerability to senescent disorders.

Basic Science Studies

Biochemical studies on development and aging have been made by investigators at the VA Medical Center in Bedford, Mass. The effect of aging processes on central myelin deposition have been studied in animal models. These studies have defined qualitative differences in development and the effects of alcohol as an age-accelerator are being explored.

Investigators at the Bedford VA Medical Center have developed methods for assessing neuronal aging in-vitro using cultured neuroblastoma cells. Useful criteria include the disposition of lipofuscin pigment, lysosomal enzyme levels, latency for cell division and enzyme induction. The same investigators, by manipulating the environmental pH, have developed a nontoxic reversible method for producing aging of nondividing neuronal cells in culture. These studies promise to yield important tests for fundamental studies of the aging process.

Investigators at the North Chicago VA Medical Center have been engaged in studies dealing with the biochemistry of mucopolysaccharides and glycoproteins in aging. These studies have been related to human senile dementia, glaucoma and chronic pulmonary disease. They have found a "keratin-sulfate-like" glycan in brain tissue which decreases with age, and changes in protoglycan composition of tissues from the angle region of the eye in experimental glaucoma. These studies promise to contribute in a major fashion to our understanding of these disorders.

The biochemical substrate for memory trace formation has been studied by investigators at the Sepulveda VA Medical Center. They have shown that glutamate antagonists selectively impair memory in experimental animals. The efficacy of these antagonists, further, is highly specific in terms of stereo isomerism and the amnestic effects are distinct from convulsant activities.

Investigators at the Boston Outpatient Clinic have continued their well established and productive research on the metabolism; structure and function of mucopolysaccharides. These studies are relevant to the problems of connective tissue disorder such as chronic arthritis in geriatric patients.

At the Bedford VA Medical Center a long range study utilizing an EEG-alpha-visual stimulus biofeedback system has been continued. This non-invasive technique is being applied to the detection of human brain pathology, cortical laterallization of function and to the alerting response in aged humans. The technique of feedback EEG has been refined and is considered superior by these investigators to the computer average visual evoked response (VER). This study represents a potentially significant tool for clinical evaluation of patients.

Investigators at the Bedford VA Medical Center have also studied the effect of diet on aging rat brains by anatomical methods. Dietary restrictions from 5½ months of age produced more active animals with significantly greater longevity compared to controls.

Investigators at the Charleston (S.C.) VA Medical Center have studied the nature and origin of the amyloid plaques in the brains of patients with senile dementia. These plaques are important pathological findings in this disorder, and the findings indicate that plaques develop in situs rather than by passage through the blood brain barrier from systemic sources.

Investigators at the Palo Alto VA Medical Center have carried out electron microscopic studies on the cellular inclusions called Lewy bodies in Parkinsonism. They have reported morphological evidence which relates a helical fibrous protein in Lewy bodies to the neurofibrillary material found in senile dementia. Clinically this study suggests a possible common etiological relationship between these age-dependent disorders.

Clinical Studies

Pre-senile and senile dementia are major problems in the geriatric population, and trace metals such as aluminum have been implicated in pathogenesis. Investigators at the Pittsburgh VA Medical Center have studied the levels of aluminum in spinal fluid from patients with Alzheimer's disease and have developed an animal model of aluminum toxicity. Anatomical selectivity for aluminium binding in frontal and occipital lobes have been reported and this site selectivity is correlated to neuronal loss in these areas.

Investigators at the Baltimore VA Medical Center have studied the effects of aging on the human vascular system. Their studies have focused on calcification in the aortic valve and aortic media. These studies identify the nature of the crystalline material in the valves and vessel walls and promise to shed light on this critical pathological process.

Investigators at the Miami VA Medical Center have completed studies on the A.V. conduction system in aged animal hearts. Spontaneous conduction defects which correlated with abnormal conduction properties in the left and right bundle branches of the A.V. system were reported. These studies are clinically relevant to diagnosis and ultimate improved therapy of heart disease in the elderly.

Investigators in the Palo Alto VA Medical Center have studied age related changes in metabolism. They have reported glucose intolerance and insensitivity to insulin in aging animals, and striking elevation in plasma triglyceride levels. These studies are relevant to problems of diabetes and ather- sclerosis in aged patients.

Studies in the pathology of senile emphysema have been carried out by investigators at the St. Louis VA Medical Center. These investigators have been able to develop an animal model of the human disorder by use of the enzyme elastinase in hamsters. Structural changes in elastic connective tissue rather than loss of elastin have been proposed as the underlying cause of this disorder.

The normative aging study at the Boston Outpatient Clinic has reported data which defines the impact of age on anterior pituitary hormone function. Specifically, basal FSH and LH increased, but no change was found in production of TSH, Prolactic and growth hormones.

At the Sepulveda VA Medical Center continuing studies of normal aging changes in craniofacial and dental structures. The purpose of these studies is to predict long term adjustments and provide reliable treatment norms for geriatric dental care.

A series of psychological studies are being carried out at the Bath (N.Y.) VA Medical Center. These studies focus on adjustments to domiciliary living by aged subjects. The studies are expected to have an important bearing on acceptance by patients of the domiciliary environment and should be useful in planning long term care facilities.

Investigators at the Boston (Jamaica Plains) VA Medical Center have studied cognitive and sensory deficits in patients with presenile and other forms of dementia by psychological techniques. Distinctive neuropsychological patterns promise to offer an important diagnostic-evaluation technique for such patients.

The effects of age (expectation and practice on decision making were studied at the Boston Outpatient Clinic. The investigators reported that slower decision-making in aged individuals could be improved in terms of speed by practice and variability between groups of different ages was similarly reduced by practice.

Investigators at the Palo Alto VA Medical Center have continued a well known and productive program in psychopharmacology. Their studies are designed to develop new and better forms of treatment for patients with emotional disorders and memory deficits.

Sleep patterns as a function of age, mental illness and the effects of psychothropic drugs have been studied at the San Francisco VA Medical Center. This study focuses on the relationships postulated between altered sleep states and such cognitive functions as memory in the elderly. Data from this study will have a major impact on assessment and management of older patients.

Psycho-Social Studies in Aging

At the Wichita VA Medical Center investigators studied the adjustment of elderly persons to nursing home placement. They found that supportive therapy during the first week of placement significantly improved the life threatening stress of relocation.

These studies span a wide range from theoretical mechanism to the very practical efforts to define patient acceptance of health care systems. They emphasize the fact that geriatric medicine is a dynamic area with enormous potential for further development. Research is critical to the development, and VA research continues to be a standard bearer in geriatrics.

12. EDUCATION

During the past 3 years, the Office of Academic Affairs has provided leadership in education and training in geriatrics. Among the factors which stimulated this activity were: the awareness of the increasing age of the veteran population; the implications of this increasing age on the health/medical care needs of veterans; the legislative mandate in the Veterans Omnibus Health Care Act of 1976, Public Law 94-581, and the report of the National Academy of Sciences, "Study of Health Care for American Veterans."

In cooperation with the Offices of Extended Care and Professional Services, the thrust of the educational strategies has been directed toward health care providers, and has emanated from various VA resources, i.e., VA central office (VACO); regional medical education centers (RMEC's); geriatric research, education and clinical centers (GRECC's); and individual health care facilities. On a continuing cooperative basis, these facilities offer training programs which address the multifaceted aspects in the professional and paraprofessional care of the elderly.

Annual national seminars on aging were initiated 3 years ago for VA physicians. The scope of these seminars has been enlarged to include nurses, social workers, psychologists and other therapists. A total multidisciplinary approach has thus been incorporated into these seminars. Subsequent to the annual seminar, participants develop proposals for educational program efforts to be conducted during the year.

In November 1978, the Office of Academic Affairs in cooperation with the Offices of Extended Care, Professional Services and Dentistry presented a program in Dallas, Tex., to define and initiate strategies for programming efforts in the areas of geriatrics and gerontology. Representatives from various functional groups (clinicians, administrators, educators) from field facilities and central office had the opportunity to work in small groups to develop strategies for the care of the geriatric patient. This program was planned to coincide with the Gerontological Society meeting which was also held in Dallas. Many VA staff members were able to participate in the meeting of the Gerontological Society.

The manpower grants service program, VA Medical School Assistance, and Health Manpower Training Act of 1972, has awarded several grants to academic institutions in support of training in a variety of aspects of geriatrics. These include long-term nursing care of the aging adult, nurse practitioners in geriatric settings, and interdisciplinary training for various types of geriatric services.

The most promising educational program focusing on the development of geriatric minded health professionals is the newly established fellowship training opportunity for physicians who are board eligible or certified in internal medicine, family practice, or psychiatry. The fellowship training consists of a 2-year post residency curriculum to develop clinical excellence in geriatrics/gerontology for inpatient, ambulatory, and long-term care.

Six sites for the geriatric fellowship program became operational in July 1978. A total of nine fellows were enrolled in the program at VA medical centers located in Bedford, Mass.; Lexington, Ky.; Little Rock, Ark.; Palo Alto, Calif.; Philadelphia, Pa.; and Los Angeles (Wadsworth), Calif. In November 1978, six additional facilities were designated as sites where training will commence in July 1979. The newly designated programs will be located at the VA medical centers in Buffalo, N.Y.; Durham, N.C.; Gainesville, Fla.; Madison, Wis.; Portland, Oreg.; and Sepulveda, Calif.

In July 1979, two new fellows will begin training in each of these 12 sites each year. By 1985, a total of 132 physicians are expected to have completed this special training in geriatrics. They will play an important role in stimulating and catalyzing educational and clinical efforts in geriatrics in VA facilities, and, through joint medical school appointments, are also expected to stimulate undergraduate and graduate medical education in the schools with which the VA facilities are affiliated.

The first meeting of the 12 directors of the geriatric Fellowship programs was held in Dallas, Tex., in November in conjunction with other meetings. Beginning strategies were developed for process and outcome evaluation measures.

Planning continues for the training of other health professionals in all aspects of gerontology and geriatrics. At three centers of excellence where the geriatric fellowship program for physicians is located, interdisciplinary teams will receive training in patient centered approaches to health care for the elderly. In addition, VA education and training programs are encouraged to offer special clinical instruction in the care of older veterans to health professions students from affiliated educational institutions.

13. DEPARTMENT OF VETERANS BENEFITS

Compensation and Pension Programs

Disability and survivor benefits (pension, compensation and dependency and indemnity compensation) administered by the Department of Veterans Benefits provide all or part of the income for 1,635,338 persons age 65 or older. This total includes 796,199 veterans, 712,988 widows; 100,841 mothers; and 25,310 fathers. Approximately 260,000 veterans age 78 or older receive a 25 percent added differential in addition to their monthly pension benefit under Public Law 86-211, as amended.

The Veterans' and Survivors' Pension Improvement Act of 1978, effective January 1, 1979, provides for a new, restructured pension program. Under this program, eligible veterans will receive a level of support meeting the national standard of need. Pensioners will generally receive benefits equal to the difference between their annual income from all other sources and the appropriate income standard.

This act provides for an $800 increase in the applicable income standard for veterans of World War I. This provision is in acknowledgement of the special needs of our older veterans.

Pensioners on the current rolls will have an opportunity to elect to receive benefits under this new program.

Veterans Assistance Service

Service to area agencies on aging (AAA's) by Veterans Services Division personnel was further refined during 1978. In many areas of the country regularly scheduled visits are made to AAA's by VA personnel. All AAA's are served at least on an "on call" basis depending upon the response of the AAA's to VA's offer for service to the elderly. The conferences provided a vehicle for exchanging ideas between VA disciplines and with experts outside the VA on how to improve service.

As VA regional offices implement new ideas and innovations in service to the elderly, they are submitted to VA central office in the narrative portion of the reporting system. These innovations are then shared with all Veterans Services Divisions through periodic information bulletins. The sharing of ideas has been largely responsible for increased activities during the year.

Educational Assistance

There are roughly 500 people age 65 or over receiving VA educational benefits, of whom nearly 270 are training under chapter 34, the Veterans Readjustment Act of 1966, as amended. Widows of veterans who died of service-connected causes and wives of veterans who are permanently and totally disabled from service-connected disabilities total about 190 of the enrolees in the survivors' and dependents' educational assistance program. No close estimate of the number of recipients of vocational rehabilitation is available. While no education and rehabilitation service program is specifically designed as a service to the aged, participation in the programs continue to include a small number of aged veterans and eligible dependents.